Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHOR SHEUNG YAU
2. Date of Death (Month Day Year): FEBRUARY 24 1999
3. Time of Death: 8:30 PM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-92-4467
6. Sex: 1 ☐ M 2 XX
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1/16/1928
9. Birthplace (State or Foreign Country): CHINA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE CITY
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: XX Yes 2 ☐ No
10e. Street and Number: 4202 DORIS AVENUE
10f. Zip Code: 21225
10g. Citizen of What Country? CHINA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: ASIAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMEAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): HOCK JONG MA
18. Mother's Name (First, Middle, Maiden Surname): TEM TONG MA

19a. Informant's Name/Relationship (Type, Print): CHI KIN YAU
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4202 DORIS AVENUE, BALTIMORE, MD 21225

20a. Method of Disposition: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LORRAINE PARK CEM. | Date: 3/1
20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee: KELLY GREGORY FINK
22. Name and Address of Facility: FINK FUNERAL HOME, P.A. 426 CRAIN HWY.,S.W. GLEN BURNIE, MARYLAND 21061

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — Approximate Interval Between Onset and Death: 3-5 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: P: 11950
29d. Date signed (Month, Day, Year): FEBRUARY 24 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PIYUSH - PATEL HARBOR HOSPITAL CENTER

State Registrar

31. Date filed (Month, Day, Year): FEB 26 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06002

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Earl William Zink
2. Date of Death (Month, Day, Year): February 24, 1999
3. Time of Death: 6:15 AM
4a. Facility Name (If not institution, give street and number): 2708 Berwick Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-26-8757
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 15, 1929
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2708 Berwick Avenue
10f. Zip Code: 21234
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: Distribution

17. Father's Name (First, Middle, Last): John Henry Zink
18. Mother's Name (First, Middle, Maiden Surname): Margaret Moncrief Courlay

19a. Informant's Name/Relationship (Type, Print): Mrs. Catherine I. Zink / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2708 Berwick Avenue Baltimore, Maryland 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lakeview Memorial Gardens
Date: 2/27/99
20c. Location - City or Town, State: Eldersburg, Maryland

21. Signature of Funeral Service Licensee: Timothy Harman ▶ Timothy S. Harman
22. Name and Address of Facility: Leonard J. Ruck, Inc. Funeral Home, 5305 Harford Road Baltimore, MD 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer — Approximate Interval Between Onset and Death: 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Chi-Shiang Chen
29c. License number: D-18151
29d. Date signed (Month, Day, Year): 2-25-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chi-Shiang Chen, M.D. 98 N. Broadway #410 Balto, Md. 21231

State Registrar

31. Date filed (Month, Day, Year): FEB 26 1999
32. Registrar's Signature: ▶ Denise G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06003

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Robert Birkmire
2. Date of Death (Month, Day, Year): February 9, 1999
3. Time of Death: 3:58 PM
4a. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-05-4239
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 19, 1918
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2102 Mark Street
10f. Zip Code: 21015
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Quality Control Inspector
16b. Kind of Business/Industry: Shoe Manufacturer
17. Father's Name *(First, Middle, Last)*: Charles James Birkmire
18. Mother's Name *(First, Middle, Maiden Surname)*: Irene Rose Sutton
19a. Informant's Name/Relationship *(Type, Print)*: Opal S. Birkmire/ Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2101 Mark Street, Bel Air, MD 21015
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Gardens — Date: 2-12-99
20c. Location - City or Town, State: Bel Air, Maryland
21. Signature of Funeral Service Licensee: ▶ Stephen A. Murphy
22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: February nine, 1999
28b. Time of Injury: 3:58 P M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D0039811
29d. Date signed *(Month, Day, Year)*: 2/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jerry Adams M.D. 501 South Union Ave, Havre de Grace, MD 21078

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 11 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

218-05-4239 3:58 pm Charles Birkmire 10-1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06004

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alfred Ovington Bowman, Sr.

2. Date of Death (Month, Day, Year): February 11, 1999

3. Time of Death: 5:30 P.M.

4a. Facility Name (If not institution, give street and number): Calvert Manor Healthcare Center

4b. City, Town, or Location of Death: Rising Sun

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 213-01-8840

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Nov. 19, 1915

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Churchville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3515 McCommons Road

10f. Zip Code: 21028

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self employed

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): James A. Bowman

18. Mother's Name (First, Middle, Maiden Surname): Anna Craig

19a. Informant's Name/Relationship (Type, Print): Elma M. Bowman (Spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3515 McCommons Road, Churchville, MD 21028

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Churchville Presbyterian Cem. | Date: 2/16/99

20c. Location - City or Town, State: Churchville, MD

21. Signature of Funeral Service Licensee: Gary R. DiGiovanni

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

b. RESPIRATORY FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RECURRENT PLEURAL EFFUSION/MALIGNANT WITH UNKNOWN PRIMARY CARCINOMA
EMPHYSEMA WITH HYPOXIA, COPD
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Malcolm D. Rhulla MD

29c. License number: D0948

29d. Date signed (Month, Day, Year): 2/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P.O. Box 300 Darlington, MD 21034

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1999

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06005

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Concepcion Brady
2. Date of Death: Month Feb. Day 11 Year 1999
3. Time of Death: 0615
4a. Facility Name (If not institution, give street and number): 808 Walnut Street
4b. City, Town, or Location of Death: Pocomoke City
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 218-82-2606
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/28/1944
9. Birthplace (State or Foreign Country): Salamanca, Spain

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Pocomoke City
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 808 Walnut Street
10f. Zip Code: 21851
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☒ Yes 2 ☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Spanish

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
18b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Jose' Martin
18. Mother's Name (First, Middle, Maiden Surname): Julia Gonzalez

19a. Informant's Name/Relationship (Type, Print): James E. Brady (spouse)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 808 Walnut Street, Pocomoke City, MD 21851

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Our Lady of Grace Cemetery | Date: 2/16/99
20c. Location - City or Town, State: Middletown, Pennsylvania

21. Signature of Funeral Service Licensee: Michael A Dean M01129
22. Name and Address of Facility: Holloway Melson Funeral Home, 103 Linden Av. Pocomoke City, MD 21851

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Gastric Carcinoma
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles Starks D.O.
29c. License number: H42911
29d. Date signed (Month, Day, Year): 2/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 305 10th St Pocomoke, MD

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06006

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELMER PERRY BAKER
2. Date of Death: Month February, Day 7, Year 1999
3. Time of Death: 2242
4e. Facility Name (If not Institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 220-34-6398
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/4/04
9. Birthplace (State or Foreign Country): Balto, Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Worcester
10c. City, Town or Location: Snow Hill
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 205 S. Morris
10f. Zip Code: 21863
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1940 Coast Guard
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+): 4
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): religion/Reverend
16b. Kind of Business/Industry: Rector of Episcopal Church
17. Father's Name (First, Middle, Last): Elmer Ellsworth Baker
18. Mother's Name (First, Middle, Maiden Surname): Virginia Wilhelm (BAker)
19e. Informant's Name/Relationship (Type, Print): Jean B. Tilghman (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 208 S. Morris St., Snow Hill,Md.21863
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): All Hallows Episcopal — Date: 2/11/99
20c. Location - City or Town, State: Snow Hill,Md.
21. Signature of Funeral Service Licensee: Patricia L. Dennis
22. Name and Address of Facility: Dennis Funeral Home, P.O. Box 87 Snow Hill,Md.21863

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Elmer Baker 220 34 6398

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARDIO PULMONARY ARREST — Approximate Interval Between Onset and Death: immediately
Due to (or as a consequence of):
b. ARTHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D 50759
29d. Date signed (Month, Day, Year): 02/08/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles Folashade 540 Riverside Dr Salisbury, Md. 21801

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

3+1

State Registrar

31. Date filed (Month, Day, Year): FEB 21 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 06007

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Baldwin
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 1950
4e. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 213-07-6762
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-24-08
9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: VA
10b. County: Accomack
10c. City, Town or Location: Jenkins Bridge
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8245 Long Ln.
10f. Zip Code: 23399
10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Steel Company

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Sumame): Louise Jenkins

19a. Informant's Name/Relationship (Type, Print): Sarah Baldwin (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8245 Long Ln. Jenkins Bridge, VA 23399

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Groton's Cem.
Date: 2/20/99
20c. Location - City or Town, State: Messongo, VA.

21. Signature of Funeral Service Licensee: Keith E. Wharton
22. Name and Address of Facility: Wharton Funeral Home, 22171 Wharton Rd Accomac, VA 23301

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as e consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D 24986
29d. Date signed (Month, Day, Year): 2/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph J. Inzerillo, M.D. 3 Bi-State Boulevard, Delmar, MD 21875

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

George Baldwin

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06008

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bryan Rudell Bailey
2. Date of Death (Month, Day, Year): February 15, 1999
3. Time of Death: 2211
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-36-3599
6. Sex: 1 ☒ M 2 ☐ F
7. Age (in yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 18, 1941
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Md.
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1535 Iris Court
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Minister
16b. Kind of Business/Industry: Church
17. Father's Name (First, Middle, Last): Leonard Bailey
18. Mother's Name (First, Middle, Maiden Surname): Emily J. Parrill
19a. Interment's Name/Relationship (Type, Print): Linda L. Bailey (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1535 Iris Court Hagerstown, Md. 21740
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ringgold Cemetery | Date: Feb. 19, 1999
20c. Location - City or Town, State: Ringgold, Md.
21. Signature of Funeral Service Licensee: Dennis L. Davis
22. Name and Address of Facility: Davis Funeral Home, 12525 Bradbury Ave. Smithsburg, Md. 21783

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Coronary occlusion — Approximate Interval Between Onset and Death: sudden

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H.M. Weeks MD
29c. License number: D11266
29d. Date signed (Month, Day, Year): Feb 16 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H.M. Weeks MD 580 Northern Av Hagerstown Md

Medical Certification: To Be Completed by Physician/Medical Examiner

Bryan Rudell Bailey

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: B. Spencer

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06009

Physician-/Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GRACE J. COBB
2. Date of Death (Month, Day, Year): FEBRUARY 12, 1999
3. Time of Death: 2200
4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 222-01-9163
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 2-14-1919
9. Birthplace *(State or Foreign Country)*: DELAWARE

Usual Residence of Decedent

10a. State: DELAWARE
10b. County: SUSSEX
10c. City, Town or Location: SELBYVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: RD# 1 , BOX 120
10f. Zip Code: 19975
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 06 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SCHOOL BUS CONTRACTOR
16b. Kind of Business/Industry: PUBLIC SCHOOL TRANSPORTATION
17. Father's Name *(First, Middle, Last)*: SAMUEL B. MURRAY
18. Mother's Name *(First, Middle, Maiden Surname)*: MABEL COLLINS
19a. Informant's Name/Relationship *(Type, Print)*: JESSE S. COBB- SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: RD#1, BOX 125A, SELBYVILLE,DE. 19975
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ROXANA CEMETERY — Date: 2-16-99
20c. Location - City or Town, State: ROXANA, DELAWARE
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: MELSON FUNERAL SERVICES,LTD. FRANKFORD, DELAWARE 19945

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

GRACE COBB 222-01-9163

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. metastatic Breast Ca — ?
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: 20705
29d. Date signed *(Month, Day, Year)*: 2/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 12 Joseph A. GRASSO 145 E. CARROLL St SALISBURY MD

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 18 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06010

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maurice Collick
2. Date of Death: Month Feb Day 14 Year 1999
3. Time of Death: 5:10 pm
4a. Facility Name (If not institution, give street and number): Deer's Head Center
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 214-18-4919
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8-22-21
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: VA.
10b. County: N/A
10c. City, Town or Location: NORFOLK
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 715-W. 26th Street
10f. Zip Code: 23523
10g. Citizen of What Country?: U.S.A.

To Be Completed by Funeral Director

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck-driver
16b. Kind of Business/Industry: Cement Business
17. Father's Name (First, Middle, Last): George Collick
18. Mother's Name (First, Middle, Maiden Surname): Sarah Manuel
19a. Informant's Name/Relationship (Type, Print): Rachel Jordan (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5401 Old National Highway College Park, Ga. 30349
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Calvary Cemetary
Date: 2-20-99
20c. Location - City or Town, State: Norfolk Va. 23523
21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: Bennie Smith Funeral Home P.O. Box 331 Pocomoke City, md. 21851

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Pneumonia	2days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. COPD	Years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus 2

Arterio Sclerotic Heart Disease with Congestive Heart Failure

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Virginia A. Dulany MD CMD
29c. License number: D33905
29d. Date signed (Month, Day, Year): 2/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): V.A. Dulany, M.D. CMD; P.O. Box 2018; Salisbury, Md. 21802

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

10

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06011

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONNA ANN CROUCH
2. Date of Death: Month February Day 11 Year 1999
3. Time of Death: 7:35 pm
4a. Facility Name (If not institution, give street and number): 2206 S. Bay Drive
4b. City, Town, or Location of Death: Toddville
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 215-58-7467
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): March 27 1952
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Toddville
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 2206 S. Bay Drive
10f. Zip Code: 21672
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): teacher
16b. Kind of Business/Industry: public schools

17. Father's Name (First, Middle, Last): Frederick Dail Powley
18. Mother's Name (First, Middle, Maiden Surname): Emma Todd

19a. Informant's Name/Relationship (Type, Print): Gary L. Crouch - husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2206 S. Bay Drive, Toddville MD 21672

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dorchester Memorial Park | Date: 2-15-99
20c. Location - City or Town, State: Cambridge, Marylnad

21. Signature of Funeral Service Licensee: Kenneth R. Thomas Jr.
22. Name and Address of Facility: Thomas Funeral Home PA, 700 Locust St. Cambridge MD 21613

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic cervical cancer — 9 months
Due to (or as a consequence of):
b. Cervical cancer — 12 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mary Ann D. Moore MD
29c. License number: D31766
29d. Date signed (Month, Day, Year): 2-12-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary Ann D. Moore MD 2 Aurora St. Cambridge Md 21613

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06012

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Earl Thomas Dolan, Sr.
2. Date of Death: Month 02 Day 17 Year 99
3. Time of Death: 0900
4a. Facility Name (If not institution, give street and number): 5143 Fleming Mill Rd.
4b. City, Town, or Location of Death: Pocomoke City
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 216-10-6399
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06/29/10
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Pocomoke City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5143 Fleming Mill Rd.
10f. Zip Code: 21851
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Management
16b. Kind of Business/Industry: Lumber
17. Father's Name (First, Middle, Last): Daniel Valentine Dolan
18. Mother's Name (First, Middle, Maiden Surname): Emily Frazier
19a. Informant's Name/Relationship (Type, Print): Earl T. Dolan, Jr.(Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5143 Fleming Mill Rd. Pocomoke City, MD 21851
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Memorial Park — Date: 2/23/99
20c. Location - City or Town, State: Parkville, MD
21. Signature of Funeral Service Licensee: Michael A Dean M01129
22. Name and Address of Facility: Holloway Melson F.H., P.A. 103 Linden Ave. Pocomoke Cit, MD 21851

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Urinary Tract Hemorrhage

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Urinary Tract Cancer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death:

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles Staubs D.O.
29c. License number: M42911
29d. Date signed (Month, Day, Year): 2/17/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles Staubs D.O. 305 10th St Pocomoke MD

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State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06013

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN D. DIEHL
2. Date of Death: Month FEBRUARY Day 09 Year 1999
3. Time of Death: 2:14 PM
4a. Facility Name (If not institution, give street and number): BERLIN NURSING & REHAB. CTR.
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 174-50-3723
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 104 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-22-1894
9. Birthplace (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCESTER
10c. City, Town or Location: OCEAN PINES
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 240 OCEAN PARKWAY
10f. Zip Code: 21811
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME
17. Father's Name (First, Middle, Last): JOHN B. GARBER
18. Mother's Name (First, Middle, Maiden Surname): ELLA MOYER
19a. Informant's Name/Relationship (Type, Print): ALICE K. DIEHL
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 240 OCEAN PARKWAY BERLIN, MD., 21811
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ROLLING GREEN CEMETERY | Date: 2-12
20c. Location - City or Town, State: CAMP HILL, PA.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarct — Minuts.
Due to (or as a consequence of):
b. Coronary Artery Disease — Yes
Due to (or as a consequence of):
c. Arteriosclerosis — Yes
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Senile Dementia
Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D02026
29d. Date signed (Month, Day, Year): 2-10-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FEDERICO G. ARTHES, M.D. 46 TEAL CIRCLE BERLIN MD 21811 410-641-4400

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

RKD
99-0887-031
JEAN
DARGERT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06014

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jeanne F. Dargert
2. Date of Death (Month, Day, Year): FEBRUARY 16, 1999
3. Time of Death: 10:53A.M.
4a. Facility Name (If not institution, give street and number): 11814 SMOKETREE ROAD
4b. City, Town, or Location of Death: POTOMAC
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 338-28-8567
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 1, 1934
9. Birthplace (State or Foreign Country): IL

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11814 Smoketree Road
10f. Zip Code: 20854
10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Insurance Co.
17. Father's Name (First, Middle, Last): Arthur D. Killen
18. Mother's Name (First, Middle, Maiden Surname): Regina Albiniak
19a. Informant's Name/Relationship (Type, Print): Audrey M. Rock
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 Cleveland Avenue Waynesboro, PA 17268
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory | Date: 2/22/99
20c. Location - City or Town, State: Smithsburg, MD 21783
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Thomas L. Geisel Funeral Home, Inc. 333 Falling Spring Rd. Chambersburg, PA 17201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Cirrhosis
Due to (or as a consequence of):
b. Alcoholism
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown
24a. Was an autopsy performed? Limited 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No
25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): FEBRUARY 17, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 23 1999
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06015

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SCOTT A. EXLINE
2. Date of Death (Month Day Year): Feb-15-99
3. Time of Death: 10 30 AM
4a. Facility Name (If not institution, give street and number): 17735 Virginia Avenue
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

Funeral Director — To Be Completed by Funeral Director

5. Social Security Number: 216-38-2349
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 55 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 27, 1943
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 ☐ Yes 2 ☑ No
10e. Street and Number: 17735 Virginia Avenue
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1960-1964
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driving
16b. Kind of Business/Industry: Trucking Transport

17. Father's Name (First, Middle, Last): Auther Dequoy Exline
18. Mother's Name (First, Middle, Maiden Surname): Willa LaRue Canfield

19a. Informant's Name/Relationship (Type, Print): Georgina A. Exline/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17735 Virginia Avenue Hagerstown, Maryland 21740

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Pleasant U.M. Ch. Cem.
Date: 2-18-99
20c. Location - City or Town, State: Grafton, West Virginia

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Osborne Funeral Home, 425 S. Conococheague St. Williamsport, MD 21795

Physician /Medical Examiner — Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — Approximate Interval Between Onset and Death: years
Due to (or as a consequence of):
b. Chronic obstructive pulmonary disease — years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D21457
29d. Date signed (Month, Day, Year): 2-16-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABDUL WAHEED MD - 12821 - OAK HILL AVE. HAGERSTOWN MD

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: [signature] B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

99 06016

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Betty Marie FORD
2. DATE OF DEATH (Month, Day, Year): February 14, 1999
3. TIME OF DEATH: 8:00 a.m
4. SOCIAL SECURITY NUMBER: 219-14-8660
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 8, 1922
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 15736 Shinham Road
9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown
9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Washington
10c. CITY, TOWN OR LOCATION: Hagerstown
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 15736 Shinham Road
10f. ZIP CODE: 21740
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12 — College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife
16b. KIND OF BUSINESS/INDUSTRY: her own home
17. FATHER'S NAME (First, Middle, Last): Claude McPherson Smith
18. MOTHER'S NAME (First, Middle, Maiden Surname): Edith Lucietta Bush
19a. INFORMANT'S NAME (Type/Print): Mrs. Robin Creek/Daughter
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15814 Shinham Road, Hagerstown, Maryland 21740
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Hagerstown Crematory — DATE: Feb. 15, 1999
20c. LOCATION — City or Town, State: Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott M Minnich
22. NAME AND ADDRESS OF FACILITY: Minnich Funeral Home, 415 East Wilson Blvd., Hagerstown, Maryland 21740

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Myocardial Infarctn — Approximate Interval Between Onset and Death: < 5 minutes
DUE TO (OR AS A CONSEQUENCE OF):
b. Chronic Obstructive Pulmonary Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Mary E Money MD
29c. LICENSE NUMBER: D 23815
29d. DATE SIGNED (Month, Day, Year): ▶ 2/15/99
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mary E Money, MD 354 Mill Street, Hagerstown, Md 21740
31. DATE FILED (Month, Day, Year): FEB 16 1999
32. REGISTRAR'S SIGNATURE: Geneva G. Sparks

DHMH-16 Rev 1/89

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06017

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leo Frank Gillespie
2. Date of Death (Month Day Year): February 7, 1999
3. Time of Death: 10:15 AM
4a. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 213-36-8314
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 2, 1916
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Edgewood
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 401 Oak Street
10f. Zip Code: 21040
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nutrition Assistant
16b. Kind of Business/Industry: Health Care
17. Father's Name *(First, Middle, Last)*: Lucious Thurlo Gillespie
18. Mother's Name *(First, Middle, Maiden Surname)*: Minnie Lulu Underwood
19a. Informant's Name/Relationship *(Type, Print)*: Russell L. Gillespie/Brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 401 Oak St., Edgewood, Maryland 21040
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Gardens — Date: 2-10-99
20c. Location - City or Town, State: Bel Air, Maryland
21. Signature of Funeral Service Licensee: Howard K. McComas
22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Pneumonia — Approximate Interval Between Onset and Death: 4 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*
29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: AN MD
29c. License number: D34652
29d. Date signed *(Month, Day, Year)*: February 7, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Haswell 2 North Avenue Bel Air Maryland 21014

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

G 1/1 ESAIG, Leo. Frank

5

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 9 1999
32. Registrar's Signature: [signature]

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 99 06018

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Samuel B. Gaskins
2. Date of Death: Month 2 Day 11 Year 99
3. Time of Death: 2140
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 229-38-7502
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 20, 1928
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Virginia
10b. County: Northampton
10c. City, Town or Location: Exmore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9441 Milton Ames Road
10f. Zip Code: 23350
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: School Maintenance

17. Father's Name (First, Middle, Last): Samuel B. Gaskins
18. Mother's Name (First, Middle, Maiden Surname): Ira Rogers

19a. Informant's Name/Relationship (Type, Print): Barbara G. Kellam Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7502 Cooper Smith Ct. Nassawadox, Va. 23413

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Shiloh Baptist Church Cemetery
Date: 2/17/99
20c. Location - City or Town, State: Painter, Va.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: John O. Morris Funeral Home P.O. Box 175 Nassawadox, Va. 23413

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Acute Myelogenous Leukemia — Approximate Interval Between Onset and Death: 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: 030690
29d. Date signed (Month, Day, Year): 2/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James E. Martin, M.D., 145 E. Carroll St, Salisbury MD

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: [signature] G. Sparks

Samuel Gaskins 229 38 7502

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Cornelia Mary Gray

Certificate of Death

99 06019

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cornelia Mary Gray
2. Date of Death (Month, Day, Year): February 15 1999
3. Time of Death: 0510
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 218-24-9253
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 13, 1909
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 421 A Sumans Avenue
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic Servant
16b. Kind of Business/Industry: Hotel
17. Father's Name (First, Middle, Last): Russel Butler
18. Mother's Name (First, Middle, Maiden Surname): Ada Anchor
19a. Informant's Name/Relationship (Type, Print): Catherine Williams Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 444 Chase Street Winchester, Virginia 22601
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenlawn Memorial Park | Date: 2/18/99
20c. Location - City or Town, State: Williamsport, Maryland
21. Signature of Funeral Service Licensee: Gerald N. Minnich
22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac Street, Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Pneumonia — Approximate Interval Between Onset and Death: 11 Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Samuel Chen
29c. License number: D36655
29d. Date signed (Month, Day, Year): Feb 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1185 MT HERNA RD. HAGERSTOWN, MD 21740

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Cornelia Mary Gray

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06020

Gruber, Richard Henry

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Henry Gruber
2. Date of Death (Month, Day, Year): February 13 1999
3. Time of Death: 1005
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-07-2516
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 18, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Williamsport
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 16712 Edward Doub Road
10f. Zip Code: 21795
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: 1943-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pipe & Steam Fitter
16b. Kind of Business/Industry: Truck Manufacturer
17. Father's Name (First, Middle, Last): Richard H. Gruber
18. Mother's Name (First, Middle, Maiden Surname): Grace E. Clopper
19a. Informant's Name/Relationship (Type, Print): Adaline Elizabeth Gruber/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16712 Edward Doub Rd. Williamsport, MD 21795
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenlawn Memorial Park — Date: Feb. 16, 1999
20c. Location - City or Town, State: Williamsport, MD
21. Signature of Funeral Service Licensee: Scott E. Osborne
22. Name and Address of Facility: Osborne Funeral Home 425 S. Conococheague St. Williamsport, MD 21795

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiogenic Shock — 2 days
Due to (or as a consequence of):
b. Ischemic Cardiomyopathy — years
Due to (or as a consequence of):
c. Critical Aortic Stenosis — 6 months
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
End Stage renal disease
NM Q wave acute myocardial infarct

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Gary Papuchis MD
29c. License number: D32851
29d. Date signed (Month, Day, Year): 2/13/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Gary C. Papuchis
11110 Medical Campus Road Hagerstown MD 21742

Dr. Papuchis Gary C.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06021

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hazel Catherine Garnand
2. Date of Death (Month, Day, Year): February 12 1999
3. Time of Death: 0830
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-3513
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 14, 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Washington
10c. City, Town or Location: Smithsburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1 Blue Mt. Estates
10f. Zip Code: 21783
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home
17. Father's Name (First, Middle, Last): Walter Shank
18. Mother's Name (First, Middle, Maiden Surname): Margaret Myers
19a. Informant's Name/Relationship (Type, Print): Shirley I. Monninger (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22513 Leitersburg-Smithsburg Rd. Smithsburg, Md. 21783
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Lena Cemetery — Date: Feb. 15, 1999
20c. Location - City or Town, State: Mt. Lena, Md.
21. Signature of Funeral Service Licensee: Dennis L. Davis
22. Name and Address of Facility: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. cerebro-vascular accident — minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pneumonia, organic brain syndrome

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D32518
29d. Date signed (Month, Day, Year): 2-12-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Guedenet 100 Geeting Lane Keedysville Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature] P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Amended Line 18.
SC 2-22-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06022

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FERNAND JOSEPH GIRARD
2. Date of Death (Month Day Year): FEBRUARY 10, 1999
3. Time of Death: 3:30 A.M.
4a. Facility Name (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 014-05-5827
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 24, 1912
9. Birthplace (State or Foreign Country): CANADA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: FREDERICK
10c. City, Town or Location: JEFFERSON
10d. Inside City Limits: 1 [ ] Yes [X] No
10e. Street and Number: 4628 NEWINGTON ROAD
10f. Zip Code: 21755
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINE OPERATOR
16b. Kind of Business/Industry: PAPER MANUFACTURING
17. Father's Name (First, Middle, Last): FREDERICK GIRARD
18. Mother's Name (First, Middle, Maiden Surname): ~~LEE DUMAS~~ Lea Dumas
19a. Informant's Name/Relationship (Type, Print): GLORIA G. KIMMEL (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4628 NEWINGTON ROAD, JEFFERSON, MD. 21755
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. ROSE CEMETERY
Date: 2/15/99
20c. Location - City or Town, State: CHICOPEE, MASSACHUSETTS
21. Signature of Funeral Service Licensee: M-00849 PAUL T. LOCHSTAMPFOR Paul T. Lochstampfor
22. Name and Address of Facility: LOCHSTAMPFOR FUNERAL HOME, INC. 48 S. CHURCH STREET, WAYNESBORO, PA. 17268

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. CEREBROVASCULAR ACCIDENT — Approximate Interval Between Onset and Death: 2 DAYS

Due to (or as a consequence of): b. HYPERTENSION — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Boyd A. Duyer MD
29c. License number: D37501
29d. Date signed (Month Day, Year): 2/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BOYD A. DUYER MD 801 TOLL HOUSE AVE BLDG H-6 FREDERICK, MD 21701

State Registrar

31. Date filed (Month, Day, Year): FEB 22 1999
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06023

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hilda Eloise Gonce
2. Date of Death (Month, Day, Year): February 13, 1999
3. Time of Death: 10:05 AM
4a. Facility Name (If not institution, give street and number): Mallard Bay Care Center
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 213-14-7598
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar 27, 1909
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8 Willis Street
10f. Zip Code: 21613
10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Healthcare

17. Father's Name (First, Middle, Last): Preston Woodland
18. Mother's Name (First, Middle, Maiden Surname): Annie McGlaughlin

19a. Informant's Name/Relationship (Type, Print): Dorothy Lee Daniels Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 713 Winterberry Dr. Fredericksburg, VA 22405

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dorchester Memorial Park — Date: 2/16/99
20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Respiratory failure — 24 hrs.
Due to (or as a consequence of):
b. S/P Cerebrovascular accident — months
Due to (or as a consequence of):
c. Hypertension — years
Due to (or as a consequence of):
d. Hypertensive cardiovascular disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D 50987
29d. Date signed (Month, Day, Year): 2/15/99.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ahmed Nawaz 105 Aurora street Cambridge MD 21613.

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06024

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN JOSEPH O'BRIEN
2. Date of Death (Month, Day, Year): FEBRUARY 14, 1999
3. Time of Death: 4:30AM
4a. Facility Name (If not institution, give street and number): 5407 MALLARD LANE
4b. City, Town, or Location of Death: CAMBRIDGE
4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 051-16-9437
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 5, 1920
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: DORCHESTER
10c. City, Town or Location: CAMBRIDGE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5407 MALLARD LANE
10f. Zip Code: 21613
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1942-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CREDIT MANAGER
16b. Kind of Business/Industry: CHEMICAL COMPANY

17. Father's Name (First, Middle, Last): WILLIAM JOSEPH O'BRIEN
18. Mother's Name (First, Middle, Maiden Surname): ELLEN KENUTESEN

19a. Informant's Name/Relationship (Type, Print): MATITIA W. O'BRIEN/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5407 MALLARD LANE, CAMBRIDGE, MARYLAND 21613

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): OUR LADY OF GOOD COUNSEL — Date: 2/16/99
20c. Location - City or Town, State: SECRETARY, MARYLAND

21. Signature of Funeral Service Licensee: Leonard D. Zeller
22. Name and Address of Facility: ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Acute Myelogenous Leukemia — Approximate Interval Between Onset and Death: 6 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael A. Moskowitz MD
29c. License number: D-16609
29d. Date signed (Month, Day, Year): February 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL A. MOSKOWICZ MD. 503 BYRD ST. CAMBRIDGE MD. 21613

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06025

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNE MARIE HAMPTON
2. Date of Death: Month February Day 10 Year 1999
3. Time of Death: 10:45 AM
4a. Facility Name (If not institution, give street and number): Fallston General Hospital
4b. City, Town, or Location of Death: Fallston
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-05-1262
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/8/1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3810 Hamilton Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Caucasian
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): - -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier
16b. Kind of Business/Industry: A&P Food Store
17. Father's Name (First, Middle, Last): George O'Neal
18. Mother's Name (First, Middle, Maiden Surname): Anna Marie Hlafka
19a. Informant's Name/Relationship (Type, Print): Paul A. Hampton Jr./Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1817 Trout Farm Rd. Jarrettsville, Md. 21084
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park | Date: 2/15 1999
20c. Location - City or Town, State: Elkridge, Maryland
21. Signature of Funeral Service Licensee: ▶ M. Gladden Kurtz III
22. Name and Address of Facility: E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE MYOCARDIAL INFARCTION — 3 DAYS

Due to (or as a consequence of): b. AORTIC STENOSIS — 10 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dean L. Vassar MD
29c. License number: 016036
29d. Date signed (Month, Day, Year): February 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DEAN VASSAR, MD. 104 Plumtree Rd. Bel Air MD 21015

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1999
32. Registrar's Signature: ▶ Bernard B. Apostol

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Hampton, Anne Marie

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06026

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GEORGE HELLER
2. Date of Death: Month 2 Day 14 Year 99
3. Time of Death: 2323
4a. Facility Name *(If not institution, give street and number)*: Atlantic General Hospital
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 157-14-9558
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 2/14/25
9. Birthplace *(State or Foreign Country)*: NJ

Usual Residence of Decedent

10a. State: PA
10b. County: Monroe
10c. City, Town or Location: Saylorsburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: RR#7 Box 7750
10f. Zip Code: 18353
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1949-53
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Pressman
16b. Kind of Business/Industry: Printing Co.
17. Father's Name *(First, Middle, Last)*: George Heller
18. Mother's Name *(First, Middle, Maiden Surname)*: Amelia Johns
19a. Informant's Name/Relationship *(Type, Print)*: Marguerite Heller/ Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: RR#7 Box 7750 Saylorsburg, PA 18353
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Straw Church Cemetery
Date: 2/18/99
20c. Location - City or Town, State: Pohatcong Twp., NJ
21. Signature of Funeral Service Licensee: W. Bill Burbage
22. Name and Address of Facility: Burbage Funeral Home, 108 William St. Berlin, MD 21811

To Be Completed by Funeral Director

Heller, George 157-14-9558 2/14/25 2/14/99 2323

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. RUPTURED AORTIC ANEURYSM — FEW HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. ASCVD — FEW YEARS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dorothy C. Holzworth, M.D.
29c. License number: D 06244
29d. Date signed *(Month, Day, Year)*: 2-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST. SNOW HILL MD. 21863

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

93

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 18 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06027

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JUNE PHIANA HAWBAKER
2. Date of Death: Month FEB Day 16 Year 1999
3. Time of Death: 6:00 AM
4a. Facility Name (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 214-16-1990
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 24 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 225 W. Franklin Street
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Her own home
17. Father's Name (First, Middle, Last): Samuel M. Shaffer
18. Mother's Name (First, Middle, Maiden Surname): C. Freta Young
19a. Informant's Name/Relationship (Type, Print): Kimberly Burnett - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 225 W. Franklin St., Hagerstown, Md. 21740
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Memorial Park
Date: 2/19/99
20c. Location - City or Town, State: Hagerstown, Maryland
21. Signature of Funeral Service Licensee: ▶ Scott M Minnich
22. Name and Address of Facility: Minnich Funeral Home, 415 E. Wilson Blvd. Hagerstown, Maryland

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MEDIASTINAL TUMOR — 1998
Due to (or as a consequence of):
b. RENAL CELL CARCINOMA, RIGHT KIDNEY — 1995
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ESOPHAGEAL OBSTRUCTION
MALNUTRITION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): NONE
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Francisco G. Japzon, M.D.
29c. License number: D05821
29d. Date signed (Month, Day, Year): FEB 16 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCISCO G. JAPZON, MD 346 MILL ST. HAGERSTOWN, MD.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

HAWBAKER, JUNE

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06028

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY MAE HORINE
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 0957
4a. Facility Name (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 220-64-1782
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/30/1917
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WASHINGTON
10c. City, Town or Location: ROHRERSVILLE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 4547 LOCUST GROVE ROAD
10f. Zip Code: 21779
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 YEARS — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: PERSONAL RESIDENCE

17. Father's Name (First, Middle, Last): CHARLES B. STINE
18. Mother's Name (First, Middle, Maiden Surname): ADDIE F. POFFENBERGER

19a. Informant's Name/Relationship (Type, Print): GLENN W. HORINE, HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4547 LOCUST GROVE ROAD, ROHRERSVILLE, MD 21779

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY — Date: 02/15/1999
20c. Location - City or Town, State: LOCUST GROVE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ PAUL M. DEAN Paul M. Dean
22. Name and Address of Facility: BAST FUNERAL HOME, 7606 OLD NATIONAL PIKE, BOONSBORO, MARYLAND 21713

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Cardiac Freewall Rupture	0
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. acute inferior wall infarction	8 days
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Essential Hypertension.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D32851
29d. Date signed (Month, Day, Year): 2/11/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 11110 Medical Campus Road Hagerstown MD 21773

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Horine, Mary Mae

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: ▶ Denise G. Sparks

DHMH 16 Rev 6/95

99 06029

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Walter HAMMOND
2. DATE OF DEATH (Month, Day, Year): February 10,1999
3. TIME OF DEATH: 1137 p.m. M
4. SOCIAL SECURITY NUMBER: 220-16-2339
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 94 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Oct. 15,1904
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown
9c. COUNTY OF DEATH: Maryland

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Washington
10c. CITY, TOWN OR LOCATION: Williamsport
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Milestone Garden Apts. 1E
10f. ZIP CODE: 21795
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): truck driver
16b. KIND OF BUSINESS/INDUSTRY: distributor
17. FATHER'S NAME (First, Middle, Last): Christian Albert Hammond
18. MOTHER'S NAME (First, Middle, Maiden Surname): Molly Jane Marmaduke
19a. INFORMANT'S NAME (Type/Print): Charles L. DeLouney
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13604 Paradise Dr., Hagerstown, Md. 21742
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rose Hill Cemetery DATE 2-15-99
20c. LOCATION — City or Town, State: Hagerstown,Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott Minnich
22. NAME AND ADDRESS OF FACILITY: MINNICH FUNERAL HOME 415 E.Wilson Blvd.,Hagerstown,Md.21740

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Subdural hematoma
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): Feb.10,1999
28b. TIME OF INJURY: 3:00 p.m.
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: fell down steps
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Milestone Apts.,Williamsport, Md.
29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Deputy Medical Examiner
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ Feb 11 1999
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Arthur H. Horn, M.D., 818 Virginia Ave., Hagerstown, Md. 21740
31. DATE FILED (Month, Day, Year): FEB 16 1999
32. REGISTRAR'S SIGNATURE: B. Sparks

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06030

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Thelma Pauline Hurley
2. Date of Death (Month Day Year): Feb. 12, 1999
3. Time of Death: 11:00 am
4a. Facility Name (If not institution, give street and number): Shore Nursing & Rehabilitation Center
4b. City, Town, or Location of Death: Denton
4c. County of Death: Caroline
5. Social Security Number: 220-10-6009
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 21, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Denton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 410 Colonial Drive
10f. Zip Code: 21629
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 6
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nursing Teacher
16b. Kind of Business/Industry: Health Education
17. Father's Name (First, Middle, Last): Lou Emory Hurley
18. Mother's Name (First, Middle, Maiden Surname): Emma Ida Kragenbrink
19a. Informant's Name/Relationship (Type, Print): Brenda F. Bornt/Cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 842, Westminster, MD 21158
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): East New Market Cem. — Date: 2-15-99
20c. Location - City or Town, State: East New Market, MD
21. Signature of Funeral Service Licensee: Joanne Curran-Bromwell
22. Name and Address of Facility: Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Pneumonia — Approximate Interval Between Onset and Death: 1wk

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D32036
29d. Date signed (Month, Day, Year): 2/14/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gay J. Sprague 2108 Dunbo Drive Chester, MD 21619

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06031

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Letha Hazel Jones
2. Date of Death (Month, Day, Year): February 8, 1999
3. Time of Death: 11:00 AM
4a. Facility Name (If not institution, give street and number): Nichols Boarding Home
4b. City, Town, or Location of Death: Edgewood
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 236-03-0363
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 22, 1904
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12417 Shadow Ln.
10f. Zip Code: 20715
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Alonzo (u/k) Rollins
18. Mother's Name (First, Middle, Maiden Surname): Thursa (u/k) Vanwey

19a. Informant's Name/Relationship (Type, Print): R. Jean Hannis/ Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12417 Shadow Lane, Bowie, MD 20715

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hepzibah Cemetery — Date: 2-13-99
20c. Location - City or Town, State: Hepzibah, W. Virginia

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE — 2 YEARS

Due to (or as a consequence of):
b. AORTIC STENOSIS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CEREBRAL VASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

Medical Certification: To Be Completed by Physician/Medical Examiner

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A. Nowakowski MD
29c. License number: D08096
29d. Date signed (Month, Day, Year): FEBRUARY 10, 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A NOWAKOWSKI MD 125 N. MAIN ST. BELAIR, MD 21014

State Registrar

31. Date filed (Month, Day, Year): FEB 11 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #5 PER F.H. G769 3-26-99 WR.

Certificate of Death

Reg. No. 99 06032

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie M. Jernick
2. Date of Death (Month, Day, Year): February 10 1999
3. Time of Death: 8:15 A.M.
4a. Facility Name (If not institution, give street and number): 330 South Rogers Street
4b. City, Town, or Location of Death: Aberdeen
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 220-20-7905 ~~201-03-0024~~
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 101 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 28, 1897
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 330 South Rogers Street
10f. Zip Code: 21001
10g. Citizen of Whet Country?: U.S.A.
11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: Whtie
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: In Home
17. Father's Name (First, Middle, Last): Frank Schmechel
18. Mother's Name (First, Middle, Maiden Sumeme): India Mayless
19a. Informant's Name/Relationship (Type, Print): Sally M. Liggett (Daughter)
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 330 South Rogers St., Aberdeen, Maryland 21001
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Deer Creek Cemetery
Date: 2/13/99
20c. Location - City or Town, Stete: Forest Hill, MD
21. Signature of Funeral Service Licensee: ▶ Gary R. Di Giovanni
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — Approximate Interval Between Onset and Death: 18 yrs.
Due to (or es e consequence of):
b. Arteriosclerotic Heart Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24a. Was en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶
29c. License number: D15994
29d. Date signed (Month, Day, Year): 02-11-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LeticiaS. Galvez, M.D., 625 S. Union Ave., Havre de Grace, MD 21078

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es tha burial-transit permit.

8

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1999
32. Registrar's Signature: ▶ Bernice B. Sparks

DHMH 16 Rev 6/95

99-0675-047
B.K.S

THOMAS DEAN JAMES
ITEMS: #23 PART I, 27, 28A-F PER MEO G769 3-1-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06033

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas DeaneJames
2. Date of Death (Month, Day, Year): FEB. 8, 1999
3. Time of Death: 0220 AM
4a. Facility Name (If not institution, give street and number): GREENBACKVILLE ROAD
4b. City, Town, or Location of Death: STOCKTON
4c. County of Death: WORCHESTER

Funeral Director

5. Social Security Number: 212-92-3086
6. Sex: ☒ 1 M ☐ 2 F
7. Age (In yrs. last birthday): 28 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/9/1970
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Snow Hill
10d. Inside City Limits: ☒ 1 Yes ☐ 2 No
10e. Street and Number: 4113 Market Street
10f. Zip Code: 21863
10g. Citizen of What Country?: USA

11. Marital Status: ☒ 1 Never Married ☐ 2 Married ☐ 3 Widowed ☐ 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☐ 1 Yes ☒ 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ 1 Yes ☒ 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: construction

17. Father's Name (First, Middle, Last): William Deane James
18. Mother's Name (First, Middle, Maiden Surname): Virginia Ruth Sexton

19a. Informant's Name/Relationship (Type, Print): Virginia Ruth James (mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 714 10th St., Apt. 102, Pocomoke City, MD 21851

20a. Method of Disposition: ☐ 1 Burial ☒ 2 Cremation ☐ 3 Removal from State ☐ 4 Donation ☐ 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory
Date: 2/12/99
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: Michael A Dean M01129
22. Name and Address of Facility: Holloway-Melson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. COMPRESSION ASPHYXIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? ☐ 1 Yes ☒ 2 No ☐ 3 Probably ☐ 4 Unknown

24a. Was an autopsy performed? ☒ 1 Yes ☐ 2 No

24b. Were autopsy findings available prior to completion of cause of death? ☒ 1 Yes ☐ 2 No

25. Was case referred to medical examiner? ☒ 1 Yes ☐ 2 No

26. Place of Death (Check only one): Hospital: ☐ 1 Inpatient ☐ 2 ER/Outpatient ☐ 3 DOA; Other: ☐ 4 Nursing Home ☐ 5 Residence ☒ 6 Other (Specify) AT SCENE

Medical Certification: To Be Completed by Physician/Medical Examiner

27. Manner of Death: ☐ 1 Natural ☒ 2 Accident ☐ 3 Suicide ☐ 4 Homicide ~~☐ 5 Pending~~ ☐ 6 Could not be determined investigation

28a. Date of Injury (Month, Day, Year): Feb 8, 1999
28b. Time of Injury: unknown ~~0220 AM~~
28c. Injury at Work? ☐ 1 Yes ☒ 2 No
28d. Describe how injury occurred: Driver of pick-up truck that lost control ~~Auto Accident~~
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Roadway
28f. Location (Street and Number or Rural Route Number, City or Town, State): Greenbackville Rd - Stockton MD

29a. Certifier (Check only one): ☐ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): FEB. 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06034

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roby Franklin Johnson
2. Date of Death (Month - Day - Year): 2 - 10 - 99
3. Time of Death: 4:00 am
4a. Facility Name (If not institution, give street and number): home, 5821 Onley Road
4b. City, Town, or Location of Death: Girdletree
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 071-22-0392
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-4-21
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Md.
10b. County: Worcester
10c. City, Town or Location: Girdletree
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5821 Onley Road
10f. Zip Code: 21829
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1944 to 1962
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor Motor Depart.
16b. Kind of Business/Industry: Sid Harvey, Co.,Inc.

17. Father's Name (First, Middle, Last): John Clayton Johnson
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth M. Clayton (Johnson)

19a. Informant's Name/Relationship (Type, Print): (wife) Mrs. Ginger C. Johnson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5821 Onley Road,Girdletree, Md. 21829

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Cemetery
Date: 2/13/99
20c. Location - City or Town, State: Girdletree,Md.

21. Signature of Funeral Service Licensee: Patricia L. Dennis
22. Name and Address of Facility: Dennis Funeral Home, P.O. Box 87 SNow Hill,Md.21863

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. CARDIOVASCULAR ARREST — Approximate Interval Between Onset and Death: Immediate

Due to (or as a consequence of): b. HBI

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D24924
29d. Date signed (Month, Day, Year): 2/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Ritchie C. Shoemaker, 1604 Market Street, Pocomoke,Md. 21851

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1999
32. Registrar's Signature: G. Sparks

12

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06035

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGINIA DAWN JARCY
2. Date of Death (Month, Day, Year): FEBRUARY 12 1999
3. Time of Death: 1:30 A.M.
4a. Facility Name (If not institution, give street and number): FREDERICK HEALTH CARE CENTER
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 213-40-7717
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 55 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/10/1943
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WASHINGTON
10c. City, Town or Location: GAPLAND
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3522 ROHRERSVILLE ROAD
10f. Zip Code: 21779
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YEARS — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MANAGER
16b. Kind of Business/Industry: ANTIQUE STORE
17. Father's Name (First, Middle, Last): BOB WEIDLER
18. Mother's Name (First, Middle, Maiden Surname): EDNA SMITH
19a. Informant's Name/Relationship (Type, Print): EDWARD J. JARCY, HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3522 ROHRERSVILLE ROAD, GAPLAND, MARYLAND 21779
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BOONSBORO CEMETERY — Date: 02/15/1999
20c. Location - City or Town, State: BOONSBORO, MARYLAND
21. Signature of Funeral Service Licensee: ▶ PAUL M. DEAN Paul M Dean
22. Name and Address of Facility: BAST FUNERAL HOME 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. Lymphomatoid granulomatosis — Approximate Interval Between Onset and Death: 4 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Multiple CVA's

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D21944
29d. Date signed (Month, Day, Year): 2/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jane S. Grisson MD. 300 W 8th St. Frederick, Md 21701

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NELLIE SKILLMAN KIMMEL
2. Date of Death (Month, Day, Year): February 10, 1999
3. Time of Death: 11:55 PM
4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-18-0398
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 28, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1408 Old Joppa Road
10f. Zip Code: 21085
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Service
16b. Kind of Business/Industry: Board of Education

17. Father's Name (First, Middle, Last): Edward Onion Skillman
18. Mother's Name (First, Middle, Maiden Surname): Annabelle (nmn) Montgomery

19a. Informant's Name/Relationship (Type, Print): William D. Kimmel - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1408 Old Joppa Rd., Joppa, MD 21085

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Gardens | Date: 2-13-99
20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Kelly L. McComas
22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SMALL CELL LUNG CANCER — Approximate Interval Between Onset and Death: 3 MONTHS

Due to (or as a consequence of):
b. SEPSIS — 1 WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HEPATORENAL SYNDROME

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year): —
28b. Time of Injury: — M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: —
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): —
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: D. Sharma MD
29c. License number: D 31856
29d. Date signed (Month, Day, Year): FEB. 10th, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D. SHARMA, MD 1814 BEL AIR RD FALLSTON MD 21047

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Kimmel, Nellie A. 2/10/99 2355

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06037

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH WEBB KNIGHT
2. Date of Death (Month Day Year): February 10,1999
3. Time of Death: 3:23 AM
4a. Facility Name (If not institution, give street and number): 6546 George Island Landing Rd.
4b. City, Town, or Location of Death: Stockton
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 226-64-1941
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 50 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 17,1948
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Worcester
10c. City, Town or Location: Stockton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6546 George Island Landing Rd.
10f. Zip Code: 21864
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier
16b. Kind of Business/Industry: Food Market
17. Father's Name (First, Middle, Last): Richard Webb
18. Mother's Name (First, Middle, Maiden Surname): Bertie Doughty
19a. Informant's Name/Relationship (Type, Print): Adron W. Knight Jr./Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 32487 Dream Park Dr., New Church, VA 23415
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Salem U.M. Church Cemetery — Date: 2/12/99
20c. Location - City or Town, State: Pocomoke, MD
21. Signature of Funeral Service Licensee: ▶ Michael A Dason M01129
22. Name and Address of Facility: Holloway-Melson Funeral Home, 103 Linden Ave., Pocomoke City, MD 21851

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. Lung Cancer — Approximate Interval Between Onset and Death: 3 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Chris Snyder
29c. License number: H50497
29d. Date signed (Month, Day, Year): 2/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 8 Chris S. Snyder, D.O. 108 Pine Bluff Rd Salisbury MD 21801

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06038

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Virginia Loretta Kendall
2. Date of Death (Month, Day, Year): February 16, 1999
3. Time of Death: 1:05 A.M.
4a. Facility Name *(If not institution, give street and number)*: Clearview Nursing Home
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-28-0161
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 3, 1917
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Md.
10b. County: Frederick
10c. City, Town or Location: Sabillasville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14826 Quirauk School Rd.
10f. Zip Code: 21780
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Theodore S. Forrest
18. Mother's Name *(First, Middle, Maiden Surname)*: Lola Mae Smith

19a. Informant's Name/Relationship *(Type, Print)*: Gary L. Kendall (Son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14826 Quirauk School Rd. Sabillasville, Md. 21780

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Bethel Cemetery
Date: Feb. 18, 1999
20c. Location - City or Town, State: Foxville, Md.

21. Signature of Funeral Service Licensee: Dennis L. Davis
22. Name and Address of Facility: Davis Funeral Home, 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Carcinoma of Cecum — 4 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Heart Disease with anemia
Coronary Artery Disease
Peripheral vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward Moody MD
29c. License number: DO 7857
29d. Date signed *(Month, Day, Year)*: February 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. E.B. Moody 1190 Mt. Aetna Road Hagerstown, Md. 21740

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 17 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

99 06039

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Raland KIRBY
2. DATE OF DEATH (Month, Day, Year): Feb. 14 1999
3. TIME OF DEATH: 4:45 A M
4. SOCIAL SECURITY NUMBER: 227-07-2892
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 1 1915
8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): 11210 Lakeview Drive
9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown
9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Washington
10c. CITY, TOWN OR LOCATION: Hagerstown
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11210 Lakeview Drive
10f. ZIP CODE: 21740
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: W.W. II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Stationary Engineer
16b. KIND OF BUSINESS/INDUSTRY: State Government
17. FATHER'S NAME (First, Middle, Last): Rufus Monroe Kirby
18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Edna Morgan
19a. INFORMANT'S NAME (Type/Print): Shirley D. Kirby - Wife
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11210 Lakeview Drive Hagerstown, Maryland 21740
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rest Haven Cemetery — DATE: 2/17/99
20c. LOCATION — City or Town, State: Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott Minnich
22. NAME AND ADDRESS OF FACILITY: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. lung cancer — Approximate Interval Between Onset and Death: 1 year

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Hind Hamdan MD
29c. LICENSE NUMBER: D46473
29d. DATE SIGNED (Month, Day, Year): 02/16/99
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Hind Hamdan, MD; 363 S. Cleveland Ave; Hagerstown, MD 21740
31. DATE FILED (Month, Day, Year): FEB 17 1999
32. REGISTRAR'S SIGNATURE: Geneva B. Sparks

DHMH-18 Rev 1/89

99-0850-033
crn
Marc Kilinski

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06040

Certificate of Death

Reg. No.

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): MARC ANTHONY KILINSKI
2. Date of Death (Month, Day, Year): February 14, 1999
3. Time of Death: 2:22 P.M.
4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's
5. Social Security Number: 216-02-8152
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 26 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 15, 1972
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: Cobb Island
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 16833 Atkinson Road
10f. Zip Code: 20625
10g. Citizen of What Country?: USA
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Welder
16b. Kind of Business/Industry: Stone Industrial
17. Father's Name (First, Middle, Last): Francis William Kilinski
18. Mother's Name (First, Middle, Maiden Surname): Kathryn Anne Swann Kilinski
19a. Informant's Name/Relationship (Type, Print): Francis W. Kilinski/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 306 Cobb Island, MD 20625
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Ghost Issue Cem.
Date: 2/18/99
20c. Location - City or Town, State: Issue, Maryland
21. Signature of Funeral Service Licensee: David C. Echols m00945
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME P.A. P.O. BOX 567 LA PLATA, MD 20646

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Head injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 2/13/99

28b. Time of Injury: unknown M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: subject during altercation struck head object

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State): Brent Store Road in Saint Mary's County Maryland

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. Kingsley

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): February 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999

32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06041

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOAN MARIE KENNEY
2. Date of Death (Month, Day, Year): February 11 1999
3. Time of Death: 1:15 pm
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 163-09-4397
6. Sex: 1☐ M ~~2☑~~ F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 22 1933
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: ~~1☑~~ Yes 2☐ No
10e. Street and Number: 304 Maryland Ave.
10f. Zip Code: 21613
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed ~~4☑~~ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ~~2☑~~ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ~~2☑~~ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: own home
17. Father's Name (First, Middle, Last): EMIL TARATUSKI
18. Mother's Name (First, Middle, Maiden Surname): FLORENCE WOLF
19a. Informant's Name/Relationship (Type, Print): Mrs. Eleanor Fuchs-sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 304 Maryland Ave., Cambridge MD 21613
20a. Method of Disposition: ~~1☑~~ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dorchester Memorial Park | Date: 2-15-99
20c. Location - City or Town, State: Cambridge, Maryland
21. Signature of Funeral Service Licensee: ▶ Kenneth R Thomas Jr.
22. Name and Address of Facility: Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Colon Carcinoma — Approximate Interval Between Onset and Death: 22 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes ~~2☑~~ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes ~~2☑~~ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes ~~2☑~~ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: ~~4☑~~ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: ~~1☑~~ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): ~~1☑~~ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of Certifier: ▶ [signature]
29c. License number: D39887
29d. Date signed (Month, Day, Year): 2/12/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. David H. Smith 501 Idlewild Ave. Easton MD 21601

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06042

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILDRED N. LONG
2. Date of Death: Month FEBRUARY Day 12 Year 1999
3. Time of Death: 12:15 PM
4a. Facility Name (If not institution, give street and number): BERLIN NURSING AND REHAB CENTER
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 220-24-3648
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-4-05
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCSETER
10c. City, Town or Location: OCEAN CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9900 COASTAL HIGHWAY
10f. Zip Code: 21842
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME
17. Father's Name (First, Middle, Last): CHARLES OGLE
18. Mother's Name (First, Middle, Maiden Surname): KATE LAVINIA SHUBBARD
19a. Informant's Name/Relationship (Type, Print): MARILYN FREELAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9900 COASTAL HIGHWAY OCEAN CITY, MD. 21842
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): DRUID RIDGE CEMETERY
Date: 2-16
20c. Location - City or Town, State: BALTIMORE, MD.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD.21811

Physician Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Acute Myocardial Inf.	hours.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary Artery Disease	yrs
	Due to (or as a consequence of):	
	c. Arteriosclerosis	yrs
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D02026
29d. Date signed (Month, Day, Year): 2-12-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FEDERICO ARTHES 46 TEAL CIRCLE OCEAN PINES, MD 21811 410-641-4400

10

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06043

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Harold Levy Sr.
2. Date of Death (Month, Day, Year): February 15 1999
3. Time of Death: 5:40A.M.
4a. Facility Name (If not institution, give street and number): 3 Oaktree Lane Apt. G
4b. City, Town, or Location of Death: Williamsport
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 115-05-1952
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. (If Under 1 Year: Months, Days; If Under 24 Hrs.: Hours, Min.)
8. Date of Birth (Month, Day, Year): March 5, 1920
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Williamsport
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3 Oaktree Lane Apt. G
10f. Zip Code: 21795
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retirad): Sergeant
16b. Kind of Business/Industry: State Government
17. Father's Name (First, Middle, Last): Maurice Levy
18. Mother's Name (First, Middle, Maiden Surname): Clara O. Mason
19a. Informant's Name/Relationship (Type, Print): Emmy Levy/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Oaktree Lane Apt. G Williamsport, Maryland 21795
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenlawn Memorial Park
Date: 2-18-99
20c. Location - City or Town, State: Williamsport, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Osborne Funeral Home, 425 S. Conococheague St. Williamsport, MD 21795

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. liver metastasis. — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Colon cancer. — 26 months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: lung metastasis.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hind Hamdan MD
29c. License number: D46473
29d. Date signed (Month, Day, Year): 02/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hind Hamdan, MD; 363 S. Cleveland Ave; Hagerstown, MD 21740

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06044

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sarah Lorraine Levi
2. Date of Death: Month 2 Day 10 Year 99
3. Time of Death: 8:30AM
4a. Facility Name (If not institution, give street and number): Julia Manor Nursing Home
4b. City, Town, or Location of Death: Hagerstown, Md.
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 213 18 9012b
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7/12/16
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10e. State: Md.
10b. County: Washington
10c. City, Town or Location: Hagerstown, Md.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 333 Mill Street
10f. Zip Code: 21740
10g. Citizen of What Country?: USA
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper
16b. Kind of Business/Industry: Domestic
17. Father's Name (First, Middle, Last):
18. Mother's Name (First, Middle, Maiden Surname): Mildred Levi
19a. Informant's Name/Relationship (Type, Print): Cora Levi Farquharson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 321 Henri Ave. Hagerstown, Md. 21740
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Memorial Park
Date:
20c. Location - City or Town, State: Hagerstown, Md.
21. Signature of Funeral Service Licensee: ▶ Mary Watson
22. Name and Address of Facility: Watson Funeral Home 24 W. Bethel St. Hagerstown, Md. 21740

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 33 years

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary Arrest
Due to (or as a consequence of):
b. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):
c. Diabetes Mellitus
Due to (or as a consequence of):
d. ~~Hay~~ on HD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
1) Renal Failure
2) Dehydration
3) Status post Cerebrovascular Disease
4) Peripheral Vascular Disease
5) Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Francisco Andrade MD
29c. License number: D27898
29d. Date signed (Month, Day, Year): 2/10/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCISCO L. ANDRADE 350 MILL ST. Hagerstown MD 21740

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 11 1999
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06045

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leroy Alton Laird
2. Date of Death (Month, Day, Year): FEB. 10 1999
3. Time of Death: 1:30 AM
4a. Facility Name (If not institution, give street and number): Western Maryland Hospital Center
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 211-18-3278
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 30, 1924
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10010 Coffman Avenue
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Inspector
16b. Kind of Business/Industry: Truck Manufacturer

17. Father's Name (First, Middle, Last): Joseph UNK Laird
18. Mother's Name (First, Middle, Maiden Surname): Helen UNK UNK

19a. Informant's Name/Relationship (Type, Print): Laurence Laird/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10010 Coffman Avenue Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Memorial Park | Date: 2-12-99
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Osborne Funeral Home, 425 S. Conococheague St. Williamsport, MD 21795

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Cause: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Probable Pulmonary Embolli — Approximate Interval Between Onset and Death: minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease
Gangrene, Right foot
S/P below knee amputation, left

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rose Marie Chan, M.D.
29c. License number: D76416
29d. Date signed (Month, Day, Year): Feb. 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROSE MARIE CHAN 1500 Pennsylvania Ave., Hagerstown, MD 21742

State Registrar

31. Date filed (Month, Day, Year): FEB 11 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06046

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Randall Rievone Lee, SR.
2. Date of Death (Month Day Year): February 12, 1999
3. Time of Death: 1:30 a.m.
4a. Facility Name (If not institution, give street and number): 422 - Charles Street
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 220-32-2178
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 13, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 422 - Charles Street
10f. Zip Code: 21613
10g. Citizen of What Country?: U.S.A.

To Be Completed by Funeral Director

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Food Processing Co.
17. Father's Name (First, Middle, Last): Chauncey Winfield Askins
18. Mother's Name (First, Middle, Maiden Surname): Elsie Mae Lee
19a. Informant's Name/Relationship (Type, Print): Helena Bordley Lee
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 422 Charles Street Cambridge, MD. 21613
20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cordtown Cemetery
Date: 2/17/99
20c. Location - City or Town, State: Cambridge, Maryland
21. Signature of Funeral Service Licensee: ▶ Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington St. Cambridge, Maryland 21613

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	1 yr
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Tobacco Use	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D0053253
29d. Date signed (Month, Day, Year): 2/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy J. Sniezek MD 503-A MUIR ST. CAMBRIDGE, MD 21613

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06047

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ferdinand A. Musiani
2. Date of Death: Month 02 Day 17 Year 99
3. Time of Death: 2100
4a. Facility Name (If not institution, give street and number): ATLANTIC GENERAL HOSPITAL
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 070-24-4586
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-18-24
9. Birthplace (State or Foreign Country): ITALY

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCESTER
10c. City, Town or Location: OCEAN CITY
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 118 OLD WHARF ROAD
10f. Zip Code: 21842
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RESTAURANT OWNER
16b. Kind of Business/Industry: HOSPITALITY

17. Father's Name (First, Middle, Last): UMBERTO MUSIANI
18. Mother's Name (First, Middle, Maiden Surname): ANNA COPPOLA

19a. Informant's Name/Relationship (Type, Print): ANGELO MUSIANI
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 48 CAMELOT CIRCLE OCEAN PINES, MD., 21811

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SALISBURY CREMATORY
Date: 2-22
20c. Location - City or Town, State: SALISBURY, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD.

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Musiani, Ferdinand 74 y.o.m. 10/18/24 - 2/17/99 2140 070-24-4586

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Hepatic failure End Stage Liver disease
Due to (or as a consequence of):
b. Renal failure
Due to (or as a consequence of):
c. Pseudomonas Sepsis
Due to (or as a consequence of):
d. Chronic Hepatitis C infection

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: H0053715
29d. Date signed (Month, Day, Year): 02/17/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FAITH SPARKS 1001 Philadelphia Ave Ocean City, MD

10

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

99 06048

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert Henry McPHERSON, SR.
2. DATE OF DEATH (Month, Day, Year): FEB. 15 1999
3. TIME OF DEATH: 10:00 P M
4. SOCIAL SECURITY NUMBER: 215-26-0938
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 3, 1929
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1010 Security Road
9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown
9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Washington
10c. CITY, TOWN OR LOCATION: Hagerstown
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1010 Security Road
10f. ZIP CODE: 21740
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: Unknown
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): none
16b. KIND OF BUSINESS/INDUSTRY: none
17. FATHER'S NAME (First, Middle, Last): Joseph Henry McPherson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Pauline Virginia Stevens
19a. INFORMANT'S NAME (Type/Print): Mrs. Connie Bowman/sister
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8132 Arcadia Lane, Boonsboro, Maryland 21713
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Hagerstown Crematory — DATE: Feb 20, 1999
20c. LOCATION — City or Town, State: Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott M Minnich
22. NAME AND ADDRESS OF FACILITY: Minnich Funeral Home, 415 East Wilson Blvd., Hagerstown, Maryland 21740

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Severe Chronic Obstructive lung disease — Approximate Interval Between Onset and Death: >20 years
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Peptic Ulcer Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
26d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: SAMUEL Chan
29c. LICENSE NUMBER: D36655
29d. DATE SIGNED (Month, Day, Year): FEB. 19, 1999
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type/Print): 1185 MT AETNA RD HAGERSTOWN MD 21740
31. DATE FILED (Month, Day, Year): FEB 22 1999
32. REGISTRAR'S SIGNATURE: P. Sparks

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06049

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Edmond Mongan SR.
2. Date of Death: Month February Day 14 Year 1999
3. Time of Death: 0140
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-10-3451
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 81 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb.12,1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Williamsport
10d. Inside City Limits: 1X Yes 2☐ No
10e. Street and Number: 20 West Salisbury Street
10f. Zip Code: 21795
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2X Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Housing and Urban Dev.
17. Father's Name (First, Middle, Last): Hubert B. Mongan
18. Mother's Name (First, Middle, Maiden Surname): Camilla E. McCardell
19e. Informant's Name/Relationship (Type, Print): Susan P. Mongan /Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20 West Salisbury Street Williamsport,MD 21795
20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenlawn Memorial Park
Date: 2-17-99
20c. Location - City or Town, State: Williamsport,Maryland
21. Signature of Funeral Service License: [signature]
22. Name and Address of Facility: Osborne Funeral Home 425 S. Conococheague St.Williamsport,MD 21795

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 72°

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA
Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
c. STROKE
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
RECURRENT PLEURAL EFFUSIONS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4X Unknown
24a. Was an autopsy performed? 1☐ Yes 2X No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2X No
26. Place of Death (Check only one): Hospital: 1X Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1X Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Mark J Yacyk DO
29c. License number: D 46108
29d. Date signed (Month, Day, Year): 2/14/99
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Mark J. Yacyk, M.D. 11110 Medical Campus Rd. Hagerstown,MD 21740

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

EDWIN PALMER 115 E. CHAPLINE ST. SHARPS. MD 21782

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06050

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edwin Columbus Palmer
2. Date of Death Month: Feb Day: 12 Year: 1999
3. Time of Death: 11:00 am
4a. Facility Name *(If not institution, give street and number)*: 115 East Chapline Street
4b. City, Town, or Location of Death: Sharpsburg
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 215-01-0001
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 89 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 3, 1909
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Sharpsburg
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 115 East Chapline Street
10f. Zip Code: 21782
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembler
16b. Kind of Business/Industry: Aircraft Manufacturer
17. Father's Name *(First, Middle, Last)*: James Otis Palmer
18. Mother's Name *(First, Middle, Maiden Surname)*: Nellie Rice
19a. Informant's Name/Relationship *(Type, Print)*: Lois Whisner/PR
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1173 Potomac Avenue Hagerstown, Maryland 21740
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Crematory
Date: 2-13-99
20c. Location - City or Town, State: Smithsburg, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Osborne Funeral Home, 425 S. Conococheague St. Williamsport, MD 21795

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. RECURRENT MYOCARDIAL INFARCTION	5'
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEVERE INFLUENZA

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*
29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dan H. Mulloyal MD
29c. License number: D21470
29d. Date signed *(Month, Day, Year)*: 2/12/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 11110 MEDICAL CAMPUS DRIVE HAGERSTOWN, MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 16 1999
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06051

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MYRTIS JOHNSON POWELL
2. Date of Death: Month February Day 10 Year 1999
3. Time of Death: 8:50 P.M.
4a. Facility Name (If not institution, give street and number): Western Maryland Hospital Center
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 225-42-4932
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 15, 1921
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1500 Pennsylvania Avenue
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
16b. Kind of Business/Industry
17. Father's Name (First, Middle, Last): Robert J. Powell
18. Mother's Name (First, Middle, Maiden Surname): Olivia Rawls
19a. Informant's Name/Relationship (Type, Print): Hudson R. Powell
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13524 Herman Myers Road, Hagerstown, Md. 21742
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery
Date: 02-13-99
20c. Location - City or Town, State: Hagerstown, Maryland
21. Signature of Funeral Service Licensee: R. Neal Brady
22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Metastic Cancer
Due to (or as a consequence of):
c. Carcinoma Endometrium
Due to (or as a consequence of):
d. Carcinoma Breast

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease
Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Newbold MD
29c. License number: D41112
29d. Date signed (Month, Day, Year): 10 February 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ian Newbold MD 1500 Pennsylvania Avenue, Hagerstown, Md. 21742

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1999
32. Registrar's Signature: G. Grates

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Ammended Harford County Health Dept. Line # 9 2/12/99

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #5 PER F.H. G769 3-9-99 WR.

Certificate of Death

Reg. No. 99 06052

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Ludwig Rice
2. Date of Death: Month February Day 10 Year 1999
3. Time of Death: 1845
4e. Facility Name (If not institution, give street and number): Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: City

Funeral Director

5. Social Security Number: 221-22-~~3391~~ 3399
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Apr. 5, 1936
9. Birthplace (State or Foreign Country): ~~Pennsylvania~~ Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 741 Custis Street
10f. Zip Code: 21001
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Vietnam
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Military
16b. Kind of Business/Industry: U.S. Army

17. Father's Name (First, Middle, Last): Melvin Howard Rice
18. Mother's Name (First, Middle, Maiden Surname): Camille Chappelle

19e. Informant's Name/Relationship (Type, Print): Ann Lee Rice(Spouse)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 741 Custis Street, Aberdeen, MD 21001

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Erin Cemetery
Date: 2/15/99
20c. Location - City or Town, State: Havre de Grace, MD

21. Signature of Funeral Service Licensee: ▶ Kirsten A. Ungleseber
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Myocardial Infarction — 6 hr
Due to (or as a consequence of):
b. Coronary Artery Disease — 5 yr
Due to (or as a consequence of):
c. End Stage Renal Disease — 5 yr
Due to (or as a consequence of):
d. Diabetes — 6 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): —
28b. Time of Injury: — M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred: —
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): —
28f. Location (Street and Number or Rural Route Number, City or Town, State): —

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶
29c. License number: D36870
29d. Date signed (Month, Day, Year): 2/11/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Pitt Revicki JHBMC

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

15+1

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1999
32. Registrar's Signature: ▶ Brenda B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06053

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CARL Denver ROGERS
2. Date of Death (Month, Day, Year): FEBRUARY 8 1999
3. Time of Death: 4pm
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-22-5149
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 20, 1930
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Abingdon
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 302 C Tall Pines Ct.
10f. Zip Code: 21009
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korea
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Trucking Company
17. Father's Name (First, Middle, Last): John Wesley Rogers
18. Mother's Name (First, Middle, Maiden Surname): Vena (u/k) Waugh
19a. Informant's Name/Relationship (Type, Print): Viola F. Rogers/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 302 C Tall Pines Ct., Abingdon, MD 21009
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cemetery
Date: 2-12-99
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Howard K. McComas III
22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. HYPERCAPNIA — 12 hours
Due to (or as a consequence of):
b. ACUTE RENAL FAILURE — 18 hours
Due to (or as a consequence of):
c. INTRARENAL HEMORRHAGE — 36 hours
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: P12389
29d. Date signed (Month, Day, Year): 2/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GARRETTSON ELLIS, MD 22 SOUTH GREENE STREET BALTIMORE, MARYLAND

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

14

State Registrar

31. Date filed (Month, Day, Year): FEB 11 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 06054

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DONALD GEORGE RUSE
2. Date of Death (Month, Day, Year): February 16, 1999
3. Time of Death: 12:07P.M.
4a. Facility Name *(If not institution, give street and number)*: Williamsport Retirement Village
4b. City, Town, or Location of Death: Williamsport
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 184-12-4492
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: February 7, 1911
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Williamsport
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 154 North Artizan Street
10f. Zip Code: 21795
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Milk Hauling Company
17. Father's Name *(First, Middle, Last)*: George Donald Ruse
18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha Mae Gordon
19a. Informant's Name/Relationship *(Type, Print)*: Louella M. Rowland
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13332 Blairs Valley Road, Clear Spring, Md. 21722
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Broadfording Cemetery — Date: 02-19-99
20c. Location - City or Town, State: Hagerstown, Maryland
21. Signature of Funeral Service Licensee: R Noel Brady
22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

February 16, 1999 12:07 p.m.

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER — 3 MONTHS

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

EMPHYSEMA

MULTIPLE CEREBRAL INFARCTS

23b. **Did tobacco use contribute to the cause of death?** 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T Howe MD
29c. License number: 00D33700
29d. Date signed *(Month, Day, Year)*: FEBRUARY 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TED E. HOWE 7542 OVERLOOK DRIVE, BOONSBORO, MD 21713

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Donald George Ruse

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 19 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 06055

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Adelinde Marie Randall
2. Date of Death (Month, Day, Year): February 12 1999
3. Time of Death: 2105
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 554-54-0167
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 28, 1909
9. Birthplace (State or Foreign Country): Austria

Usual Residence of Decedent

10a. State: Kansas
10b. County: Leavwnworth
10c. City, Town or Location: Leavenworth
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 308 Seneca St.
10f. Zip Code: 66048
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurses Aide
16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Karl Pittracher
18. Mother's Name (First, Middle, Maiden Surname): Maria Niedrist

19a. Informant's Name/Relationship (Type, Print): Loretta Mulcahey/neice
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13510 Spring Hill Dr. Hagerstown, Md. 21742

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sunset Memory Gardens Cemetery | Date: 2-18
20c. Location - City or Town, State: Leavenworth, Ks.

21. Signature of Funeral Service Licensee: ▶ Cheryl C. Burner, MBIE
22. Name and Address of Facility: Burner Trade Services Hagerstown, Md. 21740 1037 Dual Place

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory arrest
Due to (or as a consequence of):
b. Chronic obstructive lung Disease — years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Necrosis left foot Recent Stroke
Arteriosclerotic Cardiovascular Disease
Atrial fibrillation Malnutrition Decubitus ulcer bed

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D 18127
29d. Date signed (Month, Day, Year): 2/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C.C. Su MD 370 Mill St. Hagerstown Md 21740

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Randall, Adelinde

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 06056

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lila May Smyser
2. Date of Death: Month Feb Day 16 Year 99
3. Time of Death: 1530
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 206 34 1587
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUN 1 1939
9. Birthplace (State or Foreign Country): Waynesboro, Pa.

Usual Residence of Decedent

10a. State: Pa
10b. County: Franklin
10c. City, Town or Location: Waynesboro
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 233 Memorial Dr
10f. Zip Code: 17268
10g. Citizen of What Country? USA.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+) 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Librarian
16b. Kind of Business/Industry: College

17. Father's Name (First, Middle, Last): Eugene P. Smyser
18. Mother's Name (First, Middle, Maiden Surname): Gladys Mountford

19a. Informant's Name/Relationship (Type, Print): Leroy Maxwell, Jr /Attorney
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): West Main St Waynesboro Pa 17268

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Hill Cemetery
Date: Feb 20
20c. Location - City or Town, State: Waynesboro Pa

21. Signature of Funeral Service Licensee: James A Bowersox
22. Name and Address of Facility: Grove Funeral Home, Inc 50 S Broad St Waynesboro Pa 17268

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Coronary occlusion — Approximate Interval Between Onset and Death: sudden

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D11266
29d. Date signed (Month, Day, Year): Feb 16 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H.N. Weeks M.D. 500 Northern Av Hagerstown Md

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: [signature] B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06057

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOLA BLANCHE SMITH
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 1:05 PM
4a. Facility Name (If not institution, give street and number): WILLIAMSPORT RETIREMENT VILLAGE
4b. City, Town, or Location of Death: WILLIAMSPORT
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 220-26-5925
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 7, 1906
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Washington
10c. City, Town or Location: Smithsburg
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 7 S. Main St.
10f. Zip Code: 21783
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Inspector
16b. Kind of Business/Industry: Book Co.

17. Father's Name (First, Middle, Last): Charles G. Fishack
18. Mother's Name (First, Middle, Maiden Surname): Lucy Belle Dayhoff

19a. Informant's Name/Relationship (Type, Print): John R. Smith (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 Orndorff Dr. Smithsburg, Md. 21783

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Cemetery
Date: Feb. 16, 1999
20c. Location - City or Town, State: Smithsburg, Md.

21. Signature of Funeral Service Licensee: Dennis L. Davis
22. Name and Address of Facility: Davis Funeral Home, 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. RECURRENT GALLBLADDER CARCINOMA — MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: STAFF PHYSICIAN
29c. License number: D42046
29d. Date signed (Month, Day, Year): February 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GRACE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND 20860

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06058

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TWILA M. SHADE
2. Date of Death: Month JAN. Day 28 Year 1999
3. Time of Death: 9:30 AM
4a. Facility Name (If not institution, give street and number): 4835 HARPERS FERRY ROAD
4b. City, Town, or Location of Death: SHARPSBURG
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 235-12-1804
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT 19, 1915
9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MD
10b. County: WASHINGTON
10c. City, Town or Location: SHARPSBURG
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4835 HARPERS FERRY ROAD
10f. Zip Code: 21782
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME
17. Father's Name (First, Middle, Last): ROY GROVES
18. Mother's Name (First, Middle, Maiden Surname): GRACIE JUDY
19a. Informant's Name/Relationship (Type, Print): PAUL B. SHADE, II/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO BOX 32, SHARPSBURG, MD 21782
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PLEASANT VIEW MEM. GAR. | Date: 1-31-99
20c. Location - City or Town, State: MARTINSBURG, WV
21. Signature of Funeral Service Licensee: ▶ Charles M Brown
22. Name and Address of Facility: BROWN FUNERAL HOME, PO BOX 821, 327 W. KING STREET, MARTINSBURG, WV 25402

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic ovarian cancer	6 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶
29c. License number: D44996
29d. Date signed (Month, Day, Year): Feb 2, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ZAFAR MALIK MD 20311 LAPPANS RD BOONSBORO MD 21713

State Registrar

31. Date filed (Month, Day, Year): FEB 23 1999
32. Registrar's Signature: ▶ G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06059

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY KATHRYN SMERICK
2. Date of Death (Month, Day, Year): February 15, 1999
3. Time of Death: 7:15AM
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 220-10-8814
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October15,1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6124 Sea Lion Place
10f. Zip Code: 20603
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Hotel/Restaurant
17. Father's Name (First, Middle, Last): William Howard Reynolds
18. Mother's Name (First, Middle, Maiden Surname): Della Pearl Hill Reynolds
19a. Informant's Name/Relationship (Type, Print): John D. Smerick/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6124 Sea Lion Place Waldorf,MD 20603
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cem. | Date: 2/19/99 | 20c. Location - City or Town, State: Cheltenham,MD
21. Signature of Funeral Service Licensee: ▶ David C. Echols M00945
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME P.A. LA PLATA,MD 20646 P.O. Box 567

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease — years
Due to (or as a consequence of):
b. Diabetes Mellitus
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: ▶
29c. License number: D-27348
29d. Date signed (Month, Day, Year): 2/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard M. Haft,MD. 12070 Old Line Center Suite 100 Waldorf, Maryland 20602

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: ▶ Lorraine G. Sparks

Mary Kathryn Smerick

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Ammended Harford County Health Dept. Line #8 2/17/99

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06060

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lauraine Suzanne Thompson
2. Date of Death: Month 02 Day 08 Year 1999
3. Time of Death: 1229
4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 194-26-8425
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): ~~64~~ 63 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/13/~~1934~~ 1935
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 736 Tydings Road
10f. Zip Code: 21078
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 3 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Hospital
17. Father's Name (First, Middle, Last): Joseph Malloy
18. Mother's Name (First, Middle, Maiden Surname): Anna Shrader
19a. Informant's Name/Relationship (Type, Print): Joseph Thompson- Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 736 Tydings Rd., Havre de Grace, MD 21078
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): R.A. Ferris & Co. Inc.
Date: 2/12/99
20c. Location - City or Town, State: West Chester, PA
21. Signature of Funeral Service Licensee: Julaine M. Smith
22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington St. Havre de Grace, MD 21078

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Sepsis — Approximate Interval Between Onset and Death: 2 days

Due to (or as a consequence of):

b. Pneumonia, bilateral — 5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASCVD c̄ mitral valve replacement and coronary artery bypass grafting

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2■ No

26. Place of Death (Check only one): Hospital: 1■ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ramiro Lindado, MD
29c. License number: D0015466
29d. Date signed (Month, Day, Year): 2-9-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMIRO R LINDADO - HARFORD MEMORIAL HOSP. HAVRE DE GRACE MD 21078

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): FEB 11 1999
32. Registrar's Signature: P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

THOMPSON, Lauraine 2/8/99 1229

.10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06061

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Daisy Virginia Turner
2. Date of Death (Month, Day, Year): February 10 1999
3. Time of Death: 1952
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington County

Funeral Director

5. Social Security Number: 217-32-6179
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 22, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 210 East Avenue
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Private Residence

17. Father's Name (First, Middle, Last): Eldridge Jack Gaynor
18. Mother's Name (First, Middle, Maiden Surname): Margaret Elizabeth Shoemaker

19a. Informant's Name/Relationship (Type, Print): Calvin E. Turner/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 210 East Avenue, Hagerstown, Maryland 21740

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rose Hill Cemetery
Date: Feb.13
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Douglas A. Fiery
22. Name and Address of Facility: Douglas A. Fiery Funeral Home 331 Eastern Blvd.,N., Hagerstown,Maryland 21742

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	years
Due to (or as a consequence of):	b. Ischemic Heart Disease	year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D21457
29d. Date signed (Month, Day, Year): 2-12-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABDUL WAHEED, MD - 1282 - OAK HILL AVE. HAGERSTOWN. MD 21742

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1999
32. Registrar's Signature: G. Sparks

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Daisy Virginia Turner

DHMH 16 Rev 6/95

ORIGINAL

99-0766-005
B.K.S
JAMES WALKER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06062

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James David Walker
2. Date of Death: Month FEB. Day 9, Year 1999
3. Time of Death: 10:45 AM
4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL
4b. City, Town, or Location of Death: ESSEX
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-44-4847
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 22, 1947
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1807 Carsins Run Road
10f. Zip Code: 21001
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1966-70
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: Construction
17. Father's Name (First, Middle, Last): Robert B Walker
18. Mother's Name (First, Middle, Maiden Sumame): Mattie (u/k) Billings
19a. Informant's Name/Relationship (Type, Print): V. Beverly Walker/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1807 Carsins Run Rd., Aberdeen, Maryland 21001
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Gardens | Date: 2-13-99
20c. Location - City or Town, State: Bel Air, Maryland
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): FEB. 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

State Registrar

31. Date filed (Month, Day, Year): FEB 11 1999
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06063

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Norwood Kniseley Winders
2. Date of Death: Month February Day 11 Year 1999
3. Time of Death: 0549
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-12-2928
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 16, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 20013 Cool Hollow Rd.
10f. Zip Code: 21740
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dealer
16b. Kind of Business/Industry: Antiques
17. Father's Name (First, Middle, Last): Hubert B. Winders
18. Mother's Name (First, Middle, Maiden Surname): Elsie Martz
19a. Informant's Name/Relationship (Type, Print): Virginia M. Winders (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20013 Cool Hollow Rd. Hagerstown, Md. 21740
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Beaver Creek Cemetery — Date: Feb. 15, 1999
20c. Location - City or Town, State: Beaver Creek, Md.
21. Signature of Funeral Service Director: Dennis L. Davis
22. Name and Address of Facility: Davis Funeral Home, 12525 Bradbury Ave., Smithsburg, Md. 21783

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. VENTRICULAR FIBRILLATION
Due to (or as a consequence of):
b. HYPOXIA
Due to (or as a consequence of):
c. ASTHMA
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: SYED MD
29c. License number: D52055
29d. Date signed (Month, Day, Year): 2-12-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ZUBAIR M. SYED 130 W HIGH ST HANCOCK MD 21750

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Winders, Norwood Kniseley

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

PATIENT KNOWN AS ROBERT ASENDORF

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06064

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Lerch Asendorf
2. Date of Death: Month February Day 26 Year 1999
3. Time of Death: 6:06pm
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-01-6254
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 15, 1916
9. Birthplace (State or Foreign Country): Baltimore, Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: Baltimore Co.
10c. City, Town or Location: Owings Mills
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10809 Linson Road
10f. Zip Code: 21117
10g. Citizen of What Country? United States of America

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: W.W.II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): n/a
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Vice President
16b. Kind of Business/Industry: Blumenthal and Kahn Electric Co.

17. Father's Name (First, Middle, Last): Oscar Asendorf
18. Mother's Name (First, Middle, Maiden Surname): Mary L. Hoffnagle

19e. Informant's Name/Relationship (Type, Print): Mrs. Gwen E. Bray (Friend)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8326 Carbridge Circle Towson, Maryland 21204

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 3/03/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. pneumonia — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Leukemia

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Angelo Luchman MD
29c. License number: P12322
29d. Date signed (Month, Day, Year): February 26, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SINAI HOSPITAL OF BALTIMORE

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06065

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen M. Alberts
2. Date of Death (Month, Day, Year): Feb. 21, 1999
3. Time of Death: 2:45 A.M.
4a. Facility Name *(If not institution, give street and number)*: Manor Care Nursing Center
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Balto.

Funeral Director

5. Social Security Number: 208-07-6909
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 23, 1907
9. Birthplace *(State or Foreign Country)*: Pa.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2936 Sollers Point Road
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name *(First, Middle, Last)*: Michael Zelenak
18. Mother's Name *(First, Middle, Maiden Surname)*: Veronica Buttwin
19a. Informant's Name/Relationship *(Type, Print)*: John Zelenak / Brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2936 Sollers Pt. Rd., Dundalk, Md. 21222
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Balto.-Wash. Crematory — Date: 2-25-99
20c. Location - City or Town, State: Laurel, Md.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd. Balto., Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	3 months
Due to (or as a consequence of):	b. Hypertension	long standing
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Cerebro Vascular accident	10 yrs ago
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D-52205
29d. Date signed *(Month, Day, Year)*: 2/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Pratibha Sharma, 1200 S. Hanover Street Baltimore MD. 21230

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 01 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06066

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kathlyn Irene Amoss
2. Date of Death (Month, Day, Year): Feb. 26, 1999
3. Time of Death: 8:55 p.m.
4a. Facility Name (If not institution, give street and number): Carroll County Gen. Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 217-05-4596
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 9, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 28 Stocksdale Ave.
10f. Zip Code: 21136
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Saleslady
16b. Kind of Business/Industry: Dept. Store
17. Father's Name (First, Middle, Last): Andrew Schmidt
18. Mother's Name (First, Middle, Maiden Surname): Katherine V. Montgomery
19a. Informant's Name/Relationship (Type, Print): Kathlyn Sia - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3102 Gosheff Lane, Gambrills, Md. 21054-1921
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Mem. Gardens — Date: Mar. 1, 1999
20c. Location - City or Town, State: Finksburg, Md.
21. Signature of Funeral Service Licensee: H. J. Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ISCHEMIC MYOCARDIOPATHY — MONTHS
Due to (or as a consequence of):
b. ATHEROSCLEROTIC CORONARY HEART DISEASE — YEAR
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Vincent J. Fiocco Jr MD
29c. License number: DO 1663
29d. Date signed (Month, Day, Year): 2/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VINCENT J. FIOCCO JR — 906C WASHINGTON RD WESTMINSTER, MD 21157

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

WRC
99-1027-005
BRUCE
BALIVS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27 PER MEO G769 3-2-99 WR.

Certificate of Death

Reg. No. 99 06067

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bruce M. Balius, Sr.
2. Date of Death (Month, Day, Year): FEB. 21, 1999
3. Time of Death: 3:20 PM.
4a. Facility Name (If not institution, give street and number): 1613 INVERNESS AVE. APT. B
4b. City, Town, or Location of Death: DUNDALK
4c. County of Death: BALTO

Funeral Director

5. Social Security Number: 213-64-8783
6. Sex: 1☐ M 2☐ F — X
7. Age (In yrs. last birthday): 38 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec.29,1960
9. Birthplace (State or Foreign Country): Balto.,Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Balto.
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No — X
10e. Street and Number: 1613 Inverness Road
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married — X 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — XX If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No — X Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: Balto. City
17. Father's Name (First, Middle, Last): Elton Balius
18. Mother's Name (First, Middle, Maiden Surname): Gloria Czntcr
19a. Informant's Name/Relationship (Type, Print): Rita Weber / Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6604 Mt. Vista Rd., Kingsville, Md. 21087
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery — Date: 3-1-99
20c. Location - City or Town, State: Balto.,Md.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bradley-Ashton-Matthews Funeral Home,Inc. 2134 Willow Spring Rd.,.Balto.,Md.21222

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): e. ASTHMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician**: The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Dennis J. Chuteno
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): FEB. 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chuteno 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06068

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILDRED LORETTA BLANEY
2. Date of Death: Month February Day 27 Year 1999
3. Time of Death: 7:50am
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-30-5037
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 76 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08/05/1922
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedant

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: CARNEY
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2708 SARAH LANE
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COOK
16b. Kind of Business/Industry: RESTAURANT

17. Father's Name (First, Middle, Last): WILLIAM CORBIN
18. Mother's Name (First, Middle, Maiden Surname): MILDRED SCRIBNOR

19a. Informant's Name/Relationship (Type, Print): LARRY CATRON,SR./SON-IN-LAW
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2708 SARAH LANE; BALTIMORE, MD 21234

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY, INC. Date: 3/1/99
20c. Location - City or Town, State: CATONSVILLE, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — 24 hr.
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):
c. Renal failure
Due to (or as a consequence of):
d. Diabetes mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis H. Odie MD
29c. License number: 191833
29d. Date signed (Month, Day, Year): 2/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Odie MD. 9000 Franklin Square Dr. Baltimore, Maryland 21237

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06069

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Napoleon Belmore, Jr.
2. Date of Death: Month February, Day 27, Year 1999
3. Time of Death: 12:27 am
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundle

Funeral Director

5. Social Security Number: 024-05-0307
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/4/1916
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Jessup
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7810 Clark Road
10f. Zip Code: 20794
10g. Citizen of Whet Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1941 1947
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Automobile
17. Father's Neme (First, Middle, Last): Napoleon Belmore, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Etta Bell
19a. Informant's Neme/Relationship (Type, Print): Verna Winifred Belmore (Wife)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7810 Clark Road Jessup, Maryland 20794
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Chesapeake Cremation Center LLC
Dete: 3/2/1999
20c. Location - City or Town, Stete: Stevensville, MD
21. Signature of Funeral Service Licensee: Michael C. Saffran
22. Name and Address of Facility: Singleton Funeral Home PA 1 Second Avenue S. W. Glen Burnie, Maryland 21061

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. Septic Shock — 10 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:

b. Abdominal Peritonitis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Coronary Arterly Disease

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings evailable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the lime, date end piece, end due lo the cause(s) and manner steted.

29b. Signature and title of certifier: Jeffrey Sagel DO
29c. License number: H40961
29d. Date signed (Month, Dey, Year): February 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey Sagel, DO North Arundel Hospital 301 Hospital Drive, Glen Burnie, MD 21061

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

BELMORE, NEPOLEON W.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06070

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ERNESTINE BUTTS-BETRAIN
2. Date of Death Month Day Year: FEB. 25, 1999
3. Time of Death: 3:50AM
4a. Facility Name (If not institution, give street and number): 447 N. MILTON AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 229-30-4680
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months Days | If Under 24 Hrs.: Hours Min.
8. Date of Birth (Month, Day, Year): APRIL 20,1927
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 447 N. MILTON AVENUE
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRO-american

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9TH | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CHILDCARE PROVIDER
16b. Kind of Business/Industry: STATE AND BALTO.CITY

17. Father's Name (First, Middle, Last): JOHN L. JONES
18. Mother's Name (First, Middle, Maiden Surname): LUCILLE BUTTS

19a. Informant's Name/Relationship (Type, Print): LINDA PARKER / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3410 ALTO ROAD BALTO, MD. 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK | Date: 3-02-99
20c. Location - City or Town, State: BALTO, MD.

21. Signature of Funeral Service Licensee: Calvin B. Scruggs, Jr.
22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Cervical Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nina J. Everett MD
29c. License number: D46444 MD
29d. Date signed (Month, Day, Year): 3/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Nina Everett 2323 E. Orleans st. Balto. MD.

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: B. Spooks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06071

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN L. BOSLEY
2. Date of Death (Month, Day, Year): February 24, 1999
3. Time of Death: 12:10PM
4a. Facility Name (If not institution, give street and number): Future Care Cherrywood
4b. City, Town, or Location of Death: Reisterstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-10-4017
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): March 24, 1904
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 26 Cockeysmill Rd.
10f. Zip Code: 21136
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Black & Decker

17. Father's Name (First, Middle, Last): Clinton Bosley
18. Mother's Name (First, Middle, Maiden Surname): Cary Price

19a. Informant's Name/Relationship (Type, Print): Linda Torbit Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 239 Cedarmere Cr., Owings Mills, MD 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Jessup Cemetery | Date: 2/26/99
20c. Location - City or Town, State: Cockeysville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	One week
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Urinary Tract Infection	Two weeks
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D33184
29d. Date signed (Month, Day, Year): February 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jonathan Kushner 114 Business Center Drive Reisterstown, MD

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 99 06072

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS CAMPHOR
2. Date of Death: Month 2 Day 24 Year 99
3. Time of Death: 4.50AM
4a. Facility Name (If not institution, give street and number): Bon Secours Hospital
4b. City, Town, or Location of Death: 2000 W. Baltimore St
4c. County of Death: NA

Funeral Director

5. Social Security Number: 218-46-8314
6. Sex: 1☐ M 2☐ F XX
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03-06-26
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 315 Ingleside Avenue
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Longshoreman

17. Father's Name (First, Middle, Last): Thomas Camphor
18. Mother's Name (First, Middle, Maiden Surname): Ida Woolridge

19a. Informant's Name/Relationship (Type, Print): Evon Little
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 808 Curley Street Baltimore, Maryland 21205

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest VA Cem.
Date: 03-02-99
20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: WM.C.March FH 1101 E. North Avenue Balatimore, Maryland 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Fungal Septicemia
Due to (or as a consequence of):
b. Bilateral Pneumonia - 2 days
Due to (or as a consequence of):
c. (L) Foot ulcer (infected) - chronic
Due to (or as a consequence of):
d. Diabetes mellitus (uncontrolled)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypercholemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D 17202
29d. Date signed (Month, Day, Year): 2/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. S. DANG M.D. 101 St Helena Ave Baltimore Md 21222

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4+1

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06073

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Cook
2. Date of Death (Month, Day, Year): February 25, 1999
3. Time of Death: 6:45pm
4a. Facility Name (If not institution, give street and number): Eastpoint Nursing Home
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 234-12-3940
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 11, 1916
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 46 Carroll Road
10f. Zip Code: 21122
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 years — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman-Post Office
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Newton Cook
18. Mother's Name (First, Middle, Maiden Surname): Helen Marie Spears

19a. Informant's Name/Relationship (Type, Print): Martha H. Taylor (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 46 Carroll Road Pasadena, Md. 21122

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven — Date: 3/1/99
20c. Location - City or Town, State: Glen Burnie, Md.

21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Left lower lobe Pneumonia

Due to (or as a consequence of): b. Congestive Heart Failure Chronic

Due to (or as a consequence of): c. End Stage Renal disease "

Due to (or as a consequence of): d. Non insulin dependent diabetes mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery disease
Chronic Atrial Fibrillation
Parkinson's disease, Anemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature], M.D.
29c. License number: D17202
29d. Date signed (Month, Day, Year): 2/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. S. DANG M.D. 101 St Helena Ave, Baltimore Md 21222

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended@1 perPhyG770 4/1/99 EW

Certificate of Death

Reg. No. 99 06074

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~Lucille~~ Lucy Gean Cloude ~~Cloude~~
2. Date of Death: Month February Day 25 Year 1999
3. Time of Death: 2:13 am
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-20-6769
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 26, 1923
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5056 Orville Avenue
10f. Zip Code: 21205
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Chalmer Sutton
18. Mother's Name (First, Middle, Maiden Surname): Clara Friend

19a. Informant's Name/Relationship (Type, Print): Keith Cloude (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8126 Del Haven Road Baltimore, Md. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Church of the Brethern Cemetery — Date: 3/1/99
20c. Location - City or Town, State: Luray, Virginia

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Intracerebral hemorrhage — 24 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M. Caccamese, MD
29c. License number: 97486
29d. Date signed (Month, Day, Year): February 25 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suzanne M. Caccamese 4940 Eastern Avenue Baltimore, Maryland 21224

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06075

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred M. Cronin
2. Date of Death (Month, Day, Year): February 23, 1999
3. Time of Death: 6:15A.M
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-18-9710
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 30, 1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7975 St. Monica Drive
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 Years — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper / Cook
16b. Kind of Business/Industry: Housekeeping
17. Father's Name (First, Middle, Last): Alexander Kisielewski
18. Mother's Name (First, Middle, Maiden Surname): Stella Stachowski
19a. Informant's Name/Relationship (Type, Print): Nephew Thomas W. Lachajczyk
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 756 Mansfield Road Baltimore, MD 21221
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Ht. of Mary Cem.
Date: 2/26/99
20c. Location - City or Town, State: Dundalk, Maryland
21. Signature of Funeral Service Licensee: ▶ Gregory E. Reed
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Cronin, Mildred
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multi-Organ Failure — 24 Hours
Due to (or as a consequence of):
b. Sepsis — 24 Hours
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ S. Raguraj
29c. License number: RD 188813
29d. Date signed (Month, Day, Year): 02/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Sinnarajah Raguraj 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ [signature]

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06076

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edgar Rudolph Coghill, Jr.
2. Date of Death (Month, Day, Year): Feb. 27, 1999
3. Time of Death: 6 a.m.
4a. Facility Name (If not institution, give street and number): 13941 Old Hanover Rd.
4b. City, Town, or Location of Death: Reisterstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-20-4728
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 9, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 13941 Old Hanover Rd.
10f. Zip Code: 21136
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber
16b. Kind of Business/Industry: Plumbing & Heating
17. Father's Name (First, Middle, Last): Edgar Rudolph Coghill
18. Mother's Name (First, Middle, Maiden Surname): Thelma Hazel Burton
19a. Informant's Name/Relationship (Type, Print): Betty Coghill - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13941 Old Hanover Rd., Reisterstown, Md. 21136
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Mem. Gardens
Date: Mar. 2, 1999
20c. Location - City or Town, State: Finksburg, Md.
21. Signature of Funeral Service Licensee: ▶ H. J. Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, Md. 21117

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. PANCREATIC CA — Approximate Interval Between Onset and Death: 3 1/2 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Flavio Kruter MD
29c. License number: D35398
29d. Date signed (Month, Day, Year): 3-1-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Flavio Kruter, MD 224 Washington Hts Westminster, MD 21157

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #18 PER F.H. G769 3-1-99 WR.

Certificate of Death

Reg. No. 99 06078

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLOTTE T. CONNOLLY
2. Date of Death (Month, Day, Year): February 24, 1999
3. Time of Death: 5:30AM
4a. Facility Name (If not institution, give street and number): FUTURECARE-CHERRYWOOD
4b. City, Town, or Location of Death: Reisterstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-09-5133
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 11, 1916
9. Birthplace (State or Foreign Country): CO

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 305 Highfalcon Rd.
10f. Zip Code: 21136
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Glenn L. Martin
17. Father's Name (First, Middle, Last): Elwood Terry
18. Mother's Name (First, Middle, Maiden Surname): Fradelia ~~Wright~~ R. RICE
19a. Informant's Name/Relationship (Type, Print): Charlotte A. Connolly-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 305 Highfalcon Rd., Reisterstown, MD 21136
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery
Date: 2/27/99
20c. Location - City or Town, State: Frederick, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Eline Funeral Home, 11824 Reisterstown Rd., Reisterstown, MD 21136

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Senescence

Due to (or as a consequence of): b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D50557
29d. Date signed (Month, Day, Year): 2/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mini Panikar 750 Main St, Reisterstown, MD 21136

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06077

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANK CHAMBERLAIN
2. Date of Death: Month FEBRUARY Day 25 Year 1999
3. Time of Death: 5:25 am
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: AA COUNTY

Funeral Director

5. Social Security Number: 218-10-1506
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 06, 1917
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 208 HENSON ROAD
10f. Zip Code: 21060
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: NAVY
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRO-american

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7TH; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CHAUFFEUR
16b. Kind of Business/Industry: MIDSHIPMAN- NAVAL ACADEMY

17. Father's Name (First, Middle, Last): IKE CHAMBERLAIN
18. Mother's Name (First, Middle, Maiden Surname): ALICE BURTON

19a. Informant's Name/Relationship (Type, Print): SADIE CHAMBERLAIN/ WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 208 HENSON ROAD, GLEN BURNIE, MD. 21060

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY
Date: MAR.1,1999
20c. Location - City or Town, State: GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee: Calvin B. Scruggs, Jr.
22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial infarction — minutes

Due to (or as a consequence of): b. Atherosclerotic Heart Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure
Diabetes Mellitus type 2

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D02583
29d. Date signed (Month, Day, Year): 2/25/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Anastacio Sybong 206 Crain Hwy Glen Burnie, Md. 21061

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Chamberlain, Frank

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06079

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN E. CASE
2. Date of Death (Month, Day, Year): FEB. 24 1999
3. Time of Death: 9:15 PM
4a. Facility Name (If not institution, give street and number): MARINER Nursing Home of Belair
4b. City, Town, or Location of Death: Belair
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 215-28-9470
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 1, 1913
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md
10b. County: BALTO
10c. City, Town or Location: CATONSVILLE, Md
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1719 MAIDEN CHOICE LANE
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BUSINESS PARTNER
16b. Kind of Business/Industry: GARAGE/STATION
17. Father's Name (First, Middle, Last): EDWARD WEITZEL
18. Mother's Name (First, Middle, Maiden Surname): KATHRYN BINDER
19a. Informant's Name/Relationship (Type, Print): DAVID H CASE, JR / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 101 N. WILLIAMS ST. BELAIR, Md. 21014
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): OAKLAWN CEM.
Date: 2/27/99
20c. Location - City or Town, State: Balto Co Md.
21. Signature of Funeral Service Licensee: Hartley Miller
22. Name and Address of Facility: HARTLEY MILLER FUNERAL HOME, LTD. 7527 Harford Rd. Balto Md 21234

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Congestive Heart Failure — 6 Months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimers, Dementia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D
29c. License number: D34652
29d. Date signed (Month, Day, Year): FEBUAR 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SCOTT Haswell 2 North AVENUE Bel Air. MD. 21014

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

CASE, HELEN

13

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06080

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard H. Davis
2. Date of Death (Month, Day, Year): February 24, 1999
3. Time of Death: 3:20 AM
4a. Facility Name (If not institution, give street and number): VA Maryland Health Care System
4b. City, Town, or Location of Death: Perry Point
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 223-16-8420
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05/19/1914
9. Birthplace (State or Foreign Country): Va.

Usual Residence of Decedent

10a. State: MD
10b. County: A.A.Co.
10c. City, Town or Location: Pasadena
10d. Inside City Limits: [X] 1 Yes 2 [ ] No
10e. Street and Number: 8678 Scorton Harbour
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 46-66
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Soldier (Career)
16b. Kind of Business/Industry: U.S. Govt. Army

17. Father's Name (First, Middle, Last): Perry Lee Davis
18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Denise Davis/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8678 Scorton Harbour Pasadena, MD 21122

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory — Date: 2/26/99
20c. Location - City or Town, State: Balto., MD

21. Signature of Funeral Service Licensee: James A. Morton
22. Name and Address of Facility: James A. Morton & Sons F.H.Inc, 1701 Laurens St. Balto., Md 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia	2 Months
Due to (or as a consequence of):	b. Respiratory Failure	2 Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.	
Due to (or es e consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Senile Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Sodhi
29c. License number: D24014
29d. Date signed (Month, Day, Year): February 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURINDERPAL SODHI, M.D., VA Maryland Health Care System, Perry Point, MD 21902

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: Geneva B. Sparks

NAME KNOWN TO PHYSICIAN: DAVIS, RICHARD H. SR. Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06081

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN EDWARD DEADY
2. Date of Death (Month, Day, Year): FEB 24, 1999
3. Time of Death: 8:51 pm
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-01-5916
6. Sex: 1 ☐ M 2 ☐ F — X
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 18, 1921
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: BALTIMORE
10c. City, Town or Location: COLGATE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 7925 GOUGH ST.
10f. Zip Code: 21224
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11TH | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): IRON WORKER
16b. Kind of Business/Industry: LOCAL 16

17. Father's Name (First, Middle, Last): JOHN DEADY
18. Mother's Name (First, Middle, Maiden Surname): MARIE NICK

19a. Informant's Name/Relationship (Type, Print): DELL DEADY/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7925 GOUGH ST. BALTIMORE, MD. 21224

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): OAK LAWN CEMETERY — Date: 2/27/99
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: ▶ Elizabeth Sebenske
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE. BALTIMORE, MD.21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Intracerebral hemorrhage — 15 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Anyne M. Caccamese, MD
29c. License number: 97486
29d. Date signed (Month, Day, Year): February 25 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suzanne M. Caccamese 4940 Eastern Avenue Baltimore, Maryland 21224

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: ▶ Renee D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

99 06082

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mabel E. Deininger
2. DATE OF DEATH (Month, Day, Year): 2 26 99
3. TIME OF DEATH: 2:55 p. M
4. SOCIAL SECURITY NUMBER: 215-01-9730
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 93 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Jan. 10, 1906
8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Genesis Perring Parkway Center
9b. CITY, TOWN OR LOCATION OF DEATH: Parkville
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8118 Bon Air Road
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY? United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home

17. FATHER'S NAME (First, Middle, Last): Harry Clayton
18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Davis

19a. INFORMANT'S NAME (Type/Print): SandraL. Main (Granddaughter)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8118 Bon Air Road Baltimore, Maryland 21234

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood — DATE: 3/2/99
20c. LOCATION — City or Town, State: Baltimore Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Milton J. Knight Jr — Milton J. Knight Jr
22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MALNUTRITION — Approximate Interval Between Onset and Death: 15 DAYS

DUE TO (OR AS A CONSEQUENCE OF):

b. PNEUMONIA

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: 047945
29d. DATE SIGNED (Month, Day, Year): February 26 1999

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HARIS ACEEM 3007 E Northern Parkway Baltimore MD 21214.

31. DATE FILED (Month, Day, Year): MAR 1 1999
32. REGISTRAR'S SIGNATURE: G. Spaeth

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06083

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CATHERINE DOHONY
2. Date of Death (Month, Day, Year): FEBRUARY 25, 1999
3. Time of Death: 8:10 pm.
4a. Facility Name (If not institution, give street and number): Oak Crest Care Center
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-18-6775
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 15, 1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3815 Hamilton Avenue
10f. Zip Code: 21206
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 Yr's | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Manager
16b. Kind of Business/Industry: Management Co.
17. Father's Name (First, Middle, Last): Nicholas W. Dohony
18. Mother's Name (First, Middle, Maiden Surname): Cecelia Creaghan
19a. Informant's Name/Relationship (Type, Print): John J. Dohony, Jr. Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3009 Bayonne Avenue Baltimore, Maryland 21214
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer | Date: 3/1/99
20c. Location - City or Town, State: Baltimore, MD 21213
21. Signature of Funeral Service Licensee: Paul L. Dattola Jr.
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, MD 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0028.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 5 years
Due to (or as a consequence of):
b. Arteriosclerotic Cardiovascular Disease — 20 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: William M Russell
29c. License number: D30182
29d. Date signed (Month, Day, Year): FEBRUARY 26, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM RUSSELL 8800 Walther Blvd Parkville MD 21234

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: Steven B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06084

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES Samuel D'AGOSTINO Sr.

2. Date of Death (Month, Day, Year): FEBRUARY 25,1999

3. Time of Death: 2:45 A.M.

4a. Facility Name (If not institution, give street and number): 707 MAIDEN CHOICE LANE APT. 3102

4b. City, Town, or Location of Death: CATONSVILLE

4c. County of Death: BALTIMORE COUNTY

Funeral Director

5. Social Security Number: 060-09-7893

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 15, 1907

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 707 Maiden Choice Lane, Apt. 3102

10f. Zip Code: 21228

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hotel Manager

16b. Kind of Business/Industry: Restauranteur

17. Father's Name (First, Middle, Last): Vincenzo D'Agostino

18. Mother's Name (First, Middle, Maiden Surname): Rosalie Giquinto

19a. Informant's Name/Relationship (Type, Print): Betty D'Agostino (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 707 Maiden Choice Lane, Catonsville, Maryland 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery | Date: 3/1/99

20c. Location - City or Town, State: Pikesville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CONGESTIVE HEART FAILURE — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: D44748

29d. Data signed (Month, Day, Year): FEBRUARY 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MATTHEW J. NARRETT 711 MAIDEN CHOICE LANE CATONSVILLE, MD 21228

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

99-1122-510
B.K.S
OLIVIA DAVIS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06085

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): OLIVIA DAVIS
2. Date of Death (Month, Day, Year): FEB. 26, 1999
3. Time of Death: 1355 PM
4a. Facility Name (If not institution, give street and number): 740 POPLAR GROVE STREET APT.#12A
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 225 16 7885
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9/9/14
9. Birthplace (State or Foreign Country): VA.

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 740 POPLAR GROVE ST. # 12A
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRO AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC WORKER
16b. Kind of Business/Industry: PRIVATE FAMILY

17. Father's Name (First, Middle, Last): TOMMY DAVIS
18. Mother's Name (First, Middle, Maiden Surname): EFFIE DAVIS

19a. Informant's Name/Relationship (Type, Print): REGINA BRELON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3604 BELLE AVE. BALTIMORE MD. 21215

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: 3/1/99
20c. Location - City or Town, State: CATONSVILLE, MD.

21. Signature of Funeral Service Licensee: ▶ Carl A. Estep
22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? inspection 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Theodore M. King
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): FEB. 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ Joanne B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06086

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thelma Y Edwards
2. Date of Death: Month 2 Day 25 Year 99
3. Time of Death: 6:48PM
4a. Facility Name (If not institution, give street and number): Saint Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-36-7118
6. Sex: 1 ☐ M 2 ☑ F
7. Age (In yrs. last birthday): 66 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9-26-32
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 2111 BRADISH AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9TH GRADE; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSE WIFE
16b. Kind of Business/Industry: DOMESTIC

17. Father's Name (First, Middle, Last): JAMES HARRIS
18. Mother's Name (First, Middle, Maiden Surname): LUCY STEVENSON

19a. Informant's Name/Relationship (Type, Print): JAMES EDWARDS / HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2111 BRADISH AVE., BALTO. MD. 21216

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN CEMETERY
Date: 3-2-99
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE, 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Pulmonary Infiltrates
Due to (or as a consequence of):
b. Diabetes Mellitus
Due to (or as a consequence of):
c. End Stage Renal Disease
Due to (or as a consequence of):
d. Cardiomyopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal Cell Carcinoma
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Mary T Behrens MD
29c. License number: D38747
29d. Date signed (Month, Day, Year): 2-25-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary T Behrens, MD 716 Maiden Choice Lane Suite 302 Balto, MD 21228

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

Medical Certification: To be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 28d PerPHY FilmG769 3-11-99 rja

Certificate of Death

Reg. No. 99 06087

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sarah Flemings
2. Date of Death: Month 02 Day 24 Year 99
3. Time of Death: 18:45
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 216-12-9906
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 8, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6116 Belair Road
10f. Zip Code: 21206
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Domestic
17. Father's Name (First, Middle, Last): Clarence Collins
18. Mother's Name (First, Middle, Maiden Surname): Alice Freeland Coats
19a. Informant's Name/Relationship (Type, Print): Norma F. Collins/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 104 Enchanted Hills Road, Owings Mills,MD#104
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: Feb.27-99
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Leander M. Coles
22. Name and Address of Facility: Tri State Funeral Service 108 W. North Avenue

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

24A

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death:

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred: ~~Sepsis (infection)~~
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sylvanus Acitu (MD)
29c. License number: 0615
29d. Date signed (Month, Day, Year): February 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SYLVANUS ACITU Good Samaritan Hospital, Baltimore, Md 21239

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06088

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET MARY FADER
2. Date of Death (Month, Day, Year): February 27, 1999
3. Time of Death: 6:10 AM
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-09-7750
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 14, 1913
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 615 Chestnut Ave. Apt. 1202
10f. Zip Code: 21204
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home maker
16b. Kind of Business/Industry: Own home
17. Father's Name (First, Middle, Last): John Robert Houck
18. Mother's Name (First, Middle, Maiden Surname): Mary E. Robinson
19a. Informant's Name/Relationship (Type, Print): Mr. John F. Fader/husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 615 Chestnut Ave. Apt. 1202 Towson, MD. 21204
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gdns. | Date: 3/2/99
20c. Location - City or Town, State: Timonium, MD.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Cirrhosis of Liver — Approximate Interval Between Onset and Death: years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): February 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley 6 BMC 6201 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Fader, Margaret 2/27/99 6:10am

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06089

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Barkley Fenton
2. Date of Death (Month, Day, Year): February 25, 1999
3. Time of Death: 8:20 AM
4a. Facility Name (If not institution, give street and number): Edenwald Nursing Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 070-24-4884
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-30-1905
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 800 Southerly Road (Dom 117)
10f. Zip Code: 21204
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Actuarial Librarian
16b. Kind of Business/Industry: George B. Buck
17. Father's Name (First, Middle, Last): Robert Barkley
18. Mother's Name (First, Middle, Maiden Surname): Margaret Mateling
19a. Informant's Name/Relationship (Type, Print): Judge John W. Souse, Jr. (Nephew)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P O Box 70, Centreville, Maryland 21617-0070
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.
Date: 2-26-99
20c. Location - City or Town, State: Towson, Maryland 21204
21. Signature of Funeral Service Licensee: ▶ Wallace S Brock, Jr.
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — Minutes

Due to (or as a consequence of):
b. Atherosclerotic Cardiovascular Disease — 15 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia
Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D34124
29d. Date signed (Month, Day, Year): 2-26-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John D. Milto M. D. 1205 York Road, Lutherville, Maryland 21093

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06090

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mertice Mae Ferguson
2. Date of Death (Month, Day, Year): February 26, 1999
3. Time of Death: 6:55 am
4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 219-03-4808
6. Sex: 1☐ M ☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 2, 1916
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince George's
10c. City, Town or Location: College Park
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 9014 Rhode Island Avenue
10f. Zip Code: 20740
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Grade 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembly Line Worker
16b. Kind of Business/Industry: Electronics Co.

17. Father's Name *(First, Middle, Last)*: Edward Byram
18. Mother's Name *(First, Middle, Maiden Surname)*: Rosa Jane Jones

19a. Informant's Name/Relationship *(Type, Print)*: Betty Wilson / daughter in law
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 902 White Way Laurel, Maryland 20707
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Emmanuel Church Cemetery — Date: March 1 1999
20c. Location - City or Town, State: Scaggsville, Md.
21. Signature of Funeral Service Licensee: Gary S. Kyg
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cerebrovascular accident — 48 hours
Due to (or as a consequence of):
b. acute myocardial infarction
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Cynthia Crawford-Green MD
29c. License number: D27650
29d. Date signed *(Month, Day, Year)*: 02-26-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cynthia Crawford-Green 2041 Georgia Avenue N.W. Washington, D.C. 20060

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 1 1999
32. Registrar's Signature: Irene G. Sparks

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 10e Per FH FilmG769 3-1-99 rja

ITEM: #

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06091

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sarah B. Fountain
2. Date of Death: Month 2 Day 24 Year 1999
3. Time of Death: 1700
4a. Facility Name (If not institution, give street and number): 2519 Marbourne Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 215-28-2831
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 68 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5-30-1930
9. Birthplace (State or Foreign Country): Va

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2519 ~~Marbourne~~ Marbourne Ave/ AVe
10f. Zip Code: 21230
10g. Citizen of What Country? U.S.A

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: Baltimore city Public School

17. Father's Name (First, Middle, Last): James R. Jones, Sr
18. Mother's Name (First, Middle, Maiden Surname): Katie Fountain

19a. Informant's Name/Relationship (Type, Print): Barbara Fountain - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2519 Marbourne Ave Balto, Md 21230

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park
Date: 3-1-99
20c. Location - City or Town, State: Arbutus, Md

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: March F.H. West 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Intestinal Obstruction — 2 months

Due to (or as a consequence of):
b. Ovarian Cancer — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Wm C Waterfield MD
29c. License number: D24356
29d. Date signed (Month, Day, Year): Feb 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wm C WATERFIELD MD St Agnes Cancer Center 900 Caton Ave Balto Md 21229

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06092

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Jane Gorrick
2. Date of Death (Month Day Year): February 25 1999
3. Time of Death: 4:40 AM
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-32-1791
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 3-18-1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Lansdowne
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 935 Catawba Court
10f. Zip Code: 21227
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Crossing Guard
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Frederick Joseph Norris
18. Mother's Name (First, Middle, Maiden Surname): Grace Woodring

19a. Informant's Name/Relationship (Type, Print): Patty Ensey / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 159 Laverne Ave. Lansdowne, Md. 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery | Date: 3-1-99
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ Alan B. Lindsay
22. Name and Address of Facility: Ambrose Funeral Home of Lansdowne 21227, 2719 Hammonds Ferry Rd. Lansdowne, Md.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	2 Days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. FOCAL COLITIS	1-2Weeks
	Due to (or as a consequence of):	
	c. LEUKOPENIA	Months
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Multiple Myeloma

Chemotherapy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Bert F. Morton MD
29c. License number: D08949
29d. Date signed (Month, Day, Year): February 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Bert F. Morton St. Agnes HealthCare 900 Caton Avenue Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ Bruce B. Spalds

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

MARY JANE GORRICK

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 5 Per FH Film G769 3-3-99 rja

Certificate of Death

Reg. No. 99 06093

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET M GRAYSON
2. Date of Death (Month, Day, Year): FEBRUARY 26, 1999
3. Time of Death: 304 PM
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 167-~~39~~ 30-0398
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 61 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 30, 1937
9. Birthplace (State or Foreign Country): Penn.

Usual Residence of Decedent

10a. State: Pa.
10b. County: Northumberland
10c. City, Town or Location: Snydertown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: General Delivery
10f. Zip Code: 17877
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yr's — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed
16b. Kind of Business/Industry: Grocery Store
17. Father's Name (First, Middle, Last): Anthony Gaughan
18. Mother's Name (First, Middle, Maiden Surname): Florence Higgins
19a. Informant's Name/Relationship (Type, Print): Mr. Louis V. Grayson - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): All Saints Cemetery
Date: 3/2/99
20c. Location - City or Town, State: Bear Gap, Pa.
21. Signature of Funeral Service Licensee: ▶ Paul L Hartzell, Jr
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, Maryland 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. RESPIRATORY FAILURE — 1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. MIXED MESODERMAL TUMOR OF UTERUS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: AS2402321-HT9299
29d. Date signed (Month, Day, Year): FEBRUARY 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HANH TRAN

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ Irene G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06094

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BESSIE MAE GIBSON
2. Date of Death (Month, Day, Year): FEB 24 99
3. Time of Death: 1535
4a. Facility Name (If not institution, give street and number): MARINER OF CATONSVILLE
4b. City, Town, or Location of Death: CATONSVILLE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 230 26 0655
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT 28, 1926
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 632 E. 35th STREET
10f. Zip Code: 21218
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YEARS | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CUSTODIAN
16b. Kind of Business/Industry: BALTIMORE CITY PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last): HEZEKIAH CLARK
18. Mother's Name (First, Middle, Maiden Surname): BESSIE MAE SHELTON

19a. Informant's Name/Relationship (Type, Print): ALBERTA DIGGS-WILLIAMS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218: 632 E 35th STREET BALTIMORE, MARYLAND

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY | Date: 3-1-99
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Jerry Harris
22. Name and Address of Facility: CHATMAN-HARRIS F.H. 5240 REISTERTOWN ROAD BALTIMORE, MARYLAND 21215

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Sepsis — 1 wk
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Ht DM, Seizure disorder
PVD s/p BKA, s/p Gastrectomy
etc.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Attend MD
29c. License number: D26942
29d. Date signed (Month, Day, Year): 3/1/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. TURAKHIA, MD 1009, Frederick Rd. Catonsville, MD 21228

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature] B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 99 06095

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALBERT M. GEORGE
2. Date of Death (Month, Day, Year): FEBRUARY 18, 1999
3. Time of Death: 2030
4a. Facility Name (If not institution, give street and number): 3801 KENILWORTH AVENUE APT # 608 W
4b. City, Town, or Location of Death: BLADENSBURG
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 219-40-0033
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 55 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 10, 1943
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: P.G. CO.
10c. City, Town or Location: BLADENBURG
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3801 KENILWORTH AVE.
10f. Zip Code: 20710
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRINTER
16b. Kind of Business/Industry: PRINTING
17. Father's Name (First, Middle, Last): CLARENCE GEORGE
18. Mother's Name (First, Middle, Maiden Surname): ADELE GROD
19a. Informant's Name/Relationship (Type, Print): MELVIN GEORGE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1908 TWIN LAKES DR. JARETTSVILLE MD 21084
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): OAKLAWN CEM. — Date: FEB. 22, 1999
20c. Location - City or Town, State: BALTO. CO. MD.
21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.
22. Name and Address of Facility: SKARDA F.H. 2829 HUDSON ST. BALTO. MD. 21224

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DME
29c. License number: D33954
29d. Date signed (Month, Day, Year): FEBRUARY 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLUE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06096

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grace L. Gainor
2. Date of Death (Month, Day, Year): February 20, 1999
3. Time of Death: 10:15 AM
4a. Facility Name (If not institution, give street and number): National Lutheran Home
4b. City, Town, or Location of Death: /Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-76-1961
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 101 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Sept.2, 1897
9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9701 Zeirs Drive
10f. Zip Code: 20850
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? unknown 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown
17. Father's Name (First, Middle, Last): Andrew Lappert
18. Mother's Name (First, Middle, Maiden Surname): Katherine Schaefer
19a. Informant's Name/Relationship (Type, Print): Earl Laught/cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 808 Jameson Road, Conford, Maryland 21093
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. Pneumonia — Approximate Interval Between Onset and Death: 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Congestive Heart failure — 2 years

Due to (or as a consequence of):

c. Arteriosclerotic Coronary Artery Disease — 40 years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Dementia, Diabetes Mellitus II, Hypertension, Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Schoen MD
29c. License number: D3668
29d. Date signed (Month, Day, Year): February 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTOPHER SCHOEN 10529 FARNHAM DR BETHESDA MD 20814

State Registrar

31. Date filed (Month, Day, Year): FEB 24 1999
32. Registrar's Signature: [illegible]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06097

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Gull
2. Date of Death: Month 02 Day 20 Year 99
3. Time of Death: 1000
4a. Facility Name (If not institution, give street and number): Johns Hopkins Geriatrics Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-09-0433
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1/18/12
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 638 S. STREEPER STREET
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FIREFIGHTER
16b. Kind of Business/Industry: BALTIMORE CITY

17. Father's Name (First, Middle, Last): ROBERT F. GULL
18. Mother's Name (First, Middle, Maiden Surname): MARGARET MITCHELL

19a. Informant's Name/Relationship (Type, Print): MR. MICHAEL A. GULL SR.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 S. KRESSON ST. BALTIMORE, MD. 21224

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. STANISLAUS CEME. | Date: 2/27
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Eugene J. Cartt Jr.
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — Approximate Interval Between Onset and Death: Hours
Due to (or as a consequence of):
b. Pneumonia — Days
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation, Schizophrenia, Cerebrovascular Accident, History of Aspiration Pneumonitis, Anemia of Chronic Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D0652243
29d. Date signed (Month, Day, Year): 02/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C.N. Arthur 5505 Bayview Circle Balto. MD 21224

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06098

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Samuel Hairston
2. Date of Death (Month, Day, Year): FEBRUARY 21 1999
3. Time of Death: 12:18 PM
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 229-16-7436
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06-04-24
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4320 Clareway Apt.#96
10f. Zip Code: 21213
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Longshoreman

17. Father's Name (First, Middle, Last): Shad Hairston
18. Mother's Name (First, Middle, Maiden Surname): Merinda Broadney

19a. Informant's Name/Relationship (Type, Print): Annie Millner
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1125 N. Patterson Park Avenue Baltimore, Md 21213

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Cemetery | Date: 02-27-99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Shannon Stokes
22. Name and Address of Facility: WM.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Gastro intestinal bleeding — Approximate Interval Between Onset and Death: 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thakkar, MD
29c. License number: AT-2438946
29d. Date signed (Month, Day, Year): February 21 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAJIV THAKKAR, Union Memorial hospital, Baltimore, MD 21218

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: Irene G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

HAIRSTON, SAMUEL

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06099

Howard, Helen Mary

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen B. Howard
2. Date of Death (Month, Day, Year): February 27, 1999
3. Time of Death: 02:57 am
4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-34-7516
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 16, 1911
9. Birthplace (State or Foreign Country): Baltimore, Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore Co.
10c. City, Town or Location: Riderwood
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1715 West Joppa Road
10f. Zip Code: 21139
10g. Citizen of What Country? United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafateria Manager
16b. Kind of Business/Industry: Baltimore Co. Schools

17. Father's Name (First, Middle, Last): Albert Hare
18. Mother's Name (First, Middle, Maiden Surname): Stella Staines

19a. Informant's Name/Relationship (Type, Print): Mr. Donald W. Howard (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12230 Dover Road Reisterstown, Maryland 21136

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Jessup Methodist Church Cem.
Date: 03/02/99
20c. Location - City or Town, State: Sparks, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair — Jeffrey L. Gair
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrest
Due to (or as a consequence of):
b. Acute MI, post 4 cont. myocardial infarct hours
Due to (or as a consequence of):
c. Hypertension
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DO FACC
29c. License number: H 18792
29d. Date signed (Month, Day, Year): 2/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES C. RICELY 6565 N. CHARLES ST. SUITE 615 TOWSON, MD. 21204

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06100

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): WENDY LEE HARDING
2. Date of Death (Month, Day, Year): FEBRUARY 22 1999
3. Time of Death: 2:14am
4a. Facility Name (If not institution, give street and number): CHURCH HOME HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A
5. Social Security Number: 217-84-3874
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 37 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08/25/1961
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 838 WOODWARD STREET
10f. Zip Code: 21230
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unknown
16b. Kind of Business/Industry: Unknown

17. Father's Name (First, Middle, Last): Adolphus J. Harding
18. Mother's Name (First, Middle, Maiden Surname): Virginia Taliaferro

19a. Informant's Name/Relationship (Type, Print): Virginia Harding
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4847 Aberdeen Avenue, Balto., MD 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park — Date: 2/27/99
20c. Location - City or Town, State: Arbutus, Maryland

21. Signature of Funeral Service Licensee: Leroy O. Dyett
22. Name and Address of Facility: LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	48 HOURS
Due to (or as a consequence of):	b. CONSTRICTIVE PERICARDITIS	2 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. RENAL FAILURE	2 YEARS
Due to (or as a consequence of):	d. VESICULOPELVIC JUNCTION STENOSIS	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D0052969
29d. Date signed (Month, Day, Year): 2/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D. BAIRST. 2835 BANEBERRY CT, BALTIMORE, MD 21209

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 212 5-9920 NAME KNOWN TO PHYS

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than natural, or Item 23a or 23e indicate any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME KNOWN TO PHYSICIAN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06101

Physician-/Medical Examiner

1. Decedent's Name (First, Middle, Last): EMMANUEL HORNBERGER
2. Date of Death (Month, Day, Year): February 27, 1999
3. Time of Death: 0018
4e. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 217-18-9578
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 18, 1922
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: DELAWARE
10b. County: SUSSEX
10c. City, Town or Location: FRANKFORD
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: RD 1, BOX 102
10f. Zip Code: 19945
10g. Citizen of What Country?: UNITED STATES
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINIST
16b. Kind of Business/Industry: DREDGING
17. Father's Name (First, Middle, Last): HENRY AMOS HORNBERGER
18. Mother's Name (First, Middle, Maiden Surname): GRACE MAY CRISPENS
19e. Informant's Name/Relationship (Type, Print): MURIEL HORNBERGER / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): RD 1, BOX 102, FRANKFORD, DELAWARE 19945
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY, INC.
Date: MARCH 3 1999
20c. Location - City or Town, State: CATONSVILLE, MARYLAND
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Emmanuel Hornberger 217-18-9578

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ARRYTHMIA
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. ASCVD
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Nicholas L. Ogburn MD.
29c. License number: D 34593
29d. Date signed (Month, Day, Year): 2/27/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nicholas L. Ogburn M.D. 201 Pine Bluff Rd. Suite 25 Salisbury Md.

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06102

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RALPH G. HENDRICKSON
2. Date of Death (Month, Day, Year): FEBRUARY 28, 1999
3. Time of Death: 9:50 AM
4a. Facility Name (If not institution, give street and number): VANTAGE HOUSE
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 244-03-0270
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 22, 1911
9. Birthplace (State or Foreign Country): OHIO

Usual Residence of Decedent

10e. State: MARYLAND
10b. County: HOWARD
10c. City, Town or Location: COLUMBIA
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5400 VANTAGE POINT ROAD
10f. Zip Code: 21044
10g. Citizen of What Country?: U.S.A.
11. Meritet Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1940-1960
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OFFICER
16b. Kind of Business/Industry: U.S. GOVERNMENT
17. Father's Name (First, Middle, Last): WILLIAM HENDERICKSON
18. Mother's Name (First, Middle, Maiden Surname): MARY EDITH GUILLER
19a. Informant's Name/Relationship (Type, Print): RAYMOND GARY HENDRICKSON (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1419 LARCH ROAD, SEVERN, MD. 21144
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARLINGTON NATIONAL CEMETERY; Date: 3/5/99
20c. Location - City or Town, State: FORT MYERS, VIRGINIA
21. Signature of Funeral Service Licensee: [signature]
22. Neme and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Myocardial Infarction — 1 Day
Due to (or es a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings evailable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, and due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D22587
29d. Dete signed (Month, Day, Year): March 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary Frank 11051 Little Patuxent Columbia, Md. 21044

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 06103

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Beulah Mae Huffman
2. Date of Death: Month Feb Day 25 Year 1999
3. Time of Death: 9 AM
4a. Facility Name (If not institution, give street and number): 8369 Gateway Drive
4b. City, Town, or Location of Death: Jessup
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 221-10-2962
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 22, 1918
9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Jessup
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8369 Gateway Drive
10f. Zip Code: 20794
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 10 | College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Orlando Tigner
18. Mother's Name (First, Middle, Maiden Surname): Florence Caldwell

19a. Informant's Name/Relationship (Type, Print): Sadie Hobbs / sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 30 Frances Street Laurel, Maryland 20723

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: Feb 26 1999
20c. Location - City or Town, State: Catonsville, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD Deputy ME
29c. License number: D31473
29d. Date signed (Month, Day, Year): Feb 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRYCE A. TOYE, MD 4565 Hemlock Cone Way Ellicott City MD 21042

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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99-1059-510
crn
Snyteria Hall

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State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, 28A-F PER MEO G769 3-11-99 WR

Certificate of Death

Reg. No. 99 06104

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): SHYTERIA ANNISA HALL
2. Date of Death (Month, Day, Year): February 23, 1999
3. Time of Death: 12:50 P.M.
4a. Facility Name (If not institution, give street and number): Bon Secours Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A
5. Social Security Number: N/A
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 0 Yrs. — If Under 1 Year: Months 9, Days; If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): May 7, 1998
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 33 N. GORMAN AVE
10f. Zip Code: 21223
10g. Citizen of What Country?: USA
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Infant
16b. Kind of Business/Industry: N/A
17. Father's Name (First, Middle, Last): ANDRE HALL
18. Mother's Name (First, Middle, Maiden Surname): PAULA SHIELDS
19a. Informant's Name/Relationship (Type, Print): PAULA SHIELDS / MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33 N. GORMAN AVE BALTIMORE Maryland
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park
Date: 3-2-99
20c. Location - City or Town, State: Woodlawn, Maryland
21. Signature of Funeral Service Licensee: Jerry Harris
22. Name and Address of Facility: CHAPMAN-HARRIS F. H. 5240 REISTERSTOWN ROAD BALTIMORE, MARYLAND 21215

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. DROWNING

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 2-23-99

28b. Time of Injury Found: 12:21 P M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: SUBJECT DROWNED IN BATHTUB

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 33 GORMAN AVENUE BALTIMORE, MARYLAND

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chutkow

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): February 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chutkow 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999

32. Registrar's Signature: Steven G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Item: 5 per F.H G-769 3/5/99 reb

Certificate of Death

Reg. No. 99 06105

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James J Hughes, Sr.
2. Date of Death: Month Feb Day 25 Year 1999
3. Time of Death: 2 20 pm
4a. Facility Name (If not institution, give street and number): The Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 132-32-1276 ~~213-32-1276~~
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 57 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 23, 1941
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3420 Chapman Road
10f. Zip Code: 21133
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): 4+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrator
16b. Kind of Business/Industry: Social Security

17. Father's Name (First, Middle, Last): John Lawrence Hughes
18. Mother's Name (First, Middle, Maiden Surname): Helen Eileen Flynn

19a. Informant's Name/Relationship (Type, Print): Gloria M. Hughes - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3420 Chapman Road; Randallstown, Maryland 21133

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Old Holy Family Cemetery
Date: 3/1/99
20c. Location - City or Town, State: Randallstown, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	1 hr
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus
Peripheral Vascular Disease
Gangrene 5th toe

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D36584
29d. Date Signed (Month, Day, Year): 2/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robt Bressler 5601 Loch Raven Blvd Suite 207

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06106

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth H. Height
2. Date of Death (Month, Day, Year): February 24, 1999
3. Time of Death: 1057 AM
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: NA

Funeral Director

5. Social Security Number: 245-64-4432
6. Sex: 1 ☐ M 2 ☑ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 11, 1925
9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10e. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 2719 Booker Drive
10f. Zip Code: 21225
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): NA
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Clothing manufact. Co.

17. Father's Name (First, Middle, Last): Floyd King
18. Mother's Name (First, Middle, Maiden Surname): Olivia Stanley

19a. Informant's Name/Relationship (Type, Print): Pearline Bazemore - Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1037 Ashburton St. Balto. Md. 21216

20e. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet | Date: 3-1-99
20c. Location - City or Town, State: Owings Mills, Md

21. Signature of Funeral Service Licensee: Wayne B. Harris
22. Name and Address of Facility: March F. H. West 4300 Wabash Ave Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Gram Negative Septicemia	72 hours
Due to (or as a consequence of):	Gastrointestinal multi-infarct with	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. neurosis and perforation	days
Due to (or as a consequence of):	c. Mesenteric Ischemia	weeks
Due to (or as a consequence of):	d. Arteriosclerotic Disease	year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertensive Disease, Adenocarcinoma Left breast, Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ernesto, MD
29c. License number: D16333
29d. Date signed (Month, Day, Year): 02/24/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERNESTO MOLFINO, MD 821 N. EUTAW ST #206 - BALTIMORE - MD 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Ruth Height

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06107

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERNICE G. HAMMEN
2. Date of Death: Month February Day 21 Year 1999
3. Time of Death: 8:25 AM
4a. Facility Name (If not institution, give street and number): UNION MEM. HOSP.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-09-5033
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): MARCH 31, 1914
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 603 S. ANNE ST APT. 514
10f. Zip Code: 21231
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4 or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WAITRESS
16b. Kind of Business/Industry: READ'S
17. Father's Name (First, Middle, Last): JOHN LEWKIEWICZ
18. Mother's Name (First, Middle, Maiden Surname): MARYANNA MASLOWSKA
19a. Informant's Name/Relationship (Type, Print): PHYLLIS BOEMMEL
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 46 KING RICHARD CT BALTO MD. 21237
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. STANISLAUS CEM.
Date: FEB 24 1999
20c. Location - City or Town, State: BALTO MD.
21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.
22. Name and Address of Facility: SKARDA F.H. 2829 HUDSON ST BALTO MD. 21224

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary artery disease — one year
Due to (or as a consequence of):
b. Respiratory failure — 1 month
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Deron Ottey M.D.
29c. License number: AT243946-M8
29d. Date signed (Month, Day, Year): February 21 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DERON OTTEY 201 E. University Parkway Baltimore MD 21218

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: Barbara G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WR 2

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06108

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE HART II
2. Date of Death: Month 02 Day 16 Year 99
3. Time of Death: 8:32 PM
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 165-22-8832
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 26, 1928
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: NJ.
10b. County: N/A
10c. City, Town or Location: SWEDESBORO
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 12 VALLEY GLEN DR.
10f. Zip Code: 08085
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SELF-EMPLOYED
16b. Kind of Business/Industry: DELIVERY SERVICE

17. Father's Name (First, Middle, Last): GEORGE J. HART JR.
18. Mother's Name (First, Middle, Maiden Surname): ANNA MALLIS

19a. Informant's Name/Relationship (Type, Print): PATRICIA HART
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 VALLEY GLEN DR. SWEDESBORO NJ. 08085

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: FEB. 18 1999
20c. Location - City or Town, State: BALTO. CO. MD.

21. Signature of Funeral Service Licensee: ▶ Thomas J. Skarda Jr.
22. Name and Address of Facility: HOFFMANN-SKARDA 3218 HUDSON ST BALTO. MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. CONGESTIVE HEART FAILURE	>10 years
Due to (or as a consequence of):	b. MYOCARDIAL INFARCTION	8 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypotension, Gastrointestinal Blood, Renal failure

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Rachna Gupta, MD
29c. License number: P12407
29d. Date signed (Month, Day, Year): 02/16/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RACHNA GUPTA 22 SOUTH GREENE STREET BALTIMORE 21209

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: G. Apostol

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06109

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Hall
2. Date of Death (Month, Day, Year): January 9, 1999
3. Time of Death: 9:42 AM
4a. Facility Name (If not institution, give street and number): 420 S. Eaton Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 213-34-6901
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Feb. 11, 1937
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 420 S. Eaton Street
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1959-62
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dental Technician
16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Obey Luther Hall
18. Mother's Name (First, Middle, Maiden Surname): Kate Montgomery

19a. Informant's Name/Relationship (Type, Print): unknown
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) | Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary Arrest
Due to (or as a consequence of):
b. Long Standing Diabetes Mellitus.
Due to (or as a consequence of):
c. Cardiac Disease
Due to (or as a consequence of):
d. End Stage Renal Disease.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jane Van MD
29c. License number: AF 266 4200
29d. Date signed (Month, Day, Year): February 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): The Johns Hopkins Bayview Medical Center

State Registrar

31. Date filed (Month, Day, Year): FEB 24 1999
32. Registrar's Signature: Nova B. Spaid

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06110

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thelma L. Harris
2. Date of Death: Month Feb Day 20 Year 1999
3. Time of Death: 8:45 Am
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 278-05-6397
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 28, 1908
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5610 Carville Avenue
10f. Zip Code: 21227
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Robert Mitchell
18. Mother's Name (First, Middle, Maiden Surname): Mayme Storer
19a. Informant's Name/Relationship (Type, Print): Todd Hammel/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5610 Carville Avenue, Baltimore, Maryland 21227
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 11 DAYS

Immediate Cause (Final disease or condition resulting in death) e. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mutombo Kankonde
29c. License number: D46704
29d. Date signed (Month, Day, Year): Feb 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MUTOMBO KANKONDE, ST AGNES HOSPITAL BLT MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): FEB 24 1999
32. Registrar's Signature: [illegible]

NAME THELMA L HARRIS

DHMH 16 Rev 6/95

99-1009-510
Albert Jefferson
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06111

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Albert Jefferson
2. Date of Death (Month, Day, Year): Feb. 20, 99
3. Time of Death: 22:58PM
4a. Facility Name *(If not institution, give street and number)*: 437 East 22nd. Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 214-64-2661
6. Sex: 1 [X] M 2 [ ] F
7. Age *(in yrs. last birthday)*: 49 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12-31-49
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1658 Bruce Court
10f. Zip Code: 21217
10g. Citizen of What Country?: USA
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade — College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer
16b. Kind of Business/Industry: various
17. Father's Name *(First, Middle, Last)*: Phillip Jefferson
18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Blackston
19a. Informant's Name/Relationship *(Type, Print)*: Alethea M. Shaw
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1658 Bruce Street Baltimore, Maryland 21217
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Voshell Mem. Gardens — Date: 02-27-99
20c. Location - City or Town, State: Dundalk, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? INSPECTION 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* AT SCENE
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*
29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: FEBRUARY 21, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LARON Locke, MD 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 1 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 1 Per PHY FilmG769 3-1-99 rja

Certificate of Death

Reg. No. 99 06112

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES L. JOHNSON
JOHNSON, CHARLES L

2. Date of Death (Month, Day, Year): FEBRUARY 26, 1999

3. Time of Death: 1:00 pm.

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 243-48-9745

6. Sex: [X] 1 M [ ] 2 F

7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03/22/37

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: Balto.

10c. City, Town or Location: Turners Station

10d. Inside City Limits: [X] 1 Yes [ ] 2 No

10e. Street and Number: 842 Peach Orchard Lane

10f. Zip Code: 21222

10g. Citizen of What Country? USA

11. Marital Status: [ ] 1 Never Married [X] 2 Married [ ] 3 Widowed [ ] 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes [ ] 2 No If Yes, Give Year or Dates: 54--58

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] 1 Yes [X] 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: U.S. Postal Ser.

17. Father's Name (First, Middle, Last): Dennis Johnson

18. Mother's Name (First, Middle, Maiden Surname): Grace Tomlin

19a. Informant's Name/Relationship (Type, Print): Joan Johnson/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 842 Peach Orchard La. Balto., Md. 21222

20a. Method of Disposition: [X] 1 Burial [ ] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [ ] 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville V.A. Cem | Date: 3/2

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: James A. Morton

22. Name and Address of Facility: James A. Morton & Sons F.H., inc 1701 Laurens St. Balto., MD 21217

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Sepsis	21 Days
	Due to (or as a consequence of): b. Aspiration pneumonia.	23 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. Squamous Cell cancer	5 years
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

Tracheostomy.

Anemia

23b. Did tobacco use contribute to the cause of death? [X] 1 Yes [ ] 2 No [ ] 3 Probably [ ] 4 Unknown

24a. Was an autopsy performed? [ ] 1 Yes [X] 2 No

24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [ ] 2 No

25. Was case referred to medical examiner? [ ] 1 Yes [X] 2 No

26. Place of Death (Check only one): Hospital: [X] 1 Inpatient [ ] 2 ER/Outpatient [ ] 3 DOA | Other: [ ] 4 Nursing Home [ ] 5 Residence [ ] 8 Other (Specify)

27. Manner of Death: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending investigation [ ] 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? [ ] 1 Yes [ ] 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): [X] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Physician, Hospital

29c. License number: RES 0000

29d. Date signed (Month, Day, Year): February 26, 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SACHS MISHELL, MD. 4940 Eastern Avenue, Baltimore MD 21224

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999

32. Registrar's Signature: Joyce B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 11,12 per F.H G-769 3/8/99 reb

Certificate of Death

Reg. No. 99 06113

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES HERBERT JOHN
2. Date of Death (Month, Day, Year): February 26,1999
3. Time of Death: 6:00 A.M.
4a. Facility Name (If not institution, give street and number): Holy Cross
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 217-18-5139
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 23,1923
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Wheaton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11610 College View Drive
10f. Zip Code: 20906
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates: 1941-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman
16b. Kind of Business/Industry: Potomac Electric & Power Company

17. Father's Name (First, Middle, Last): James Herbert John
18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Moch

19a. Informant's Name/Relationship (Type, Print): Linda Duvall/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Gaither Manor Dr. Sykesville,MD 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park — Date: 3/13/99
20c. Location - City or Town, State: Rockville,MD

21. Signature of Funeral Service Licensee: James F. Schmidt
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave. Silver Spring,MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Arrhythmia	seconds
Due to (or as a consequence of):	b. Respiratory Failure	2 weeks
Due to (or as a consequence of):	c. Adult Respiratory Distress Syndrome	2 weeks
Due to (or as a consequence of):	d. Severe Emphysemia	years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Acute Myocardial Infarction

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D20678
29d. Date signed (Month, Day, Year): Feb 26 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edwarda M. Buda, M.D. 3904 Cleveland St. Kennsington, MD 20895

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: Lena G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit stub.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item#7 perFHG769 3/1/99 EW

Certificate of Death

Reg. No. 99 06114

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FATEMEH JALALI
2. Date of Death (Month, Day, Year): FEBRUARY 16, 1999
3. Time of Death: 1042A
4a. Facility Name (If not institution, give street and number): MANOR CARE
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 218-29-4611
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 87 ~~88~~ Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR. 21, 1911
9. Birthplace (State or Foreign Country): IRAN

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: GAITHERSBURG
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 18976 MONTGOMERY VILLAGE AVENUE
10f. Zip Code: 20886
10g. Citizen of What Country?: IRAN

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): ABOL GHASEM JALALI
18. Mother's Name (First, Middle, Maiden Surname): ROGHIE (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): DARYOUSH BABAK (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18976 MONTGOMERY VILLAGE AVENUE GAITHERSBURG MARYLAND 20886

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY
Date: 2-24-99
20c. Location - City or Town, State: SILVER SPRING, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING MARYLAND 20904-2891

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARRYTHMIA — 05 MINUTES

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

RENAL INSUFFICIENCY

HYPERTENSION

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ellen M Pinholt
29c. License number: D 51015
29d. Date signed (Month, Day, Year): 2/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ELLEN PINHOLT, M.D., 5530 WISCONSIN AVENUE, SUITE #1045 CHEVY CHASE MARYLAND 20815

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06115

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES K. KOWALEWSKI
2. Date of Death (Month, Day, Year): FEBRUARY 16, 1999
3. Time of Death: 1147
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-42-3575
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 11, 1944
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2914 DILLON ST.
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISER
16b. Kind of Business/Industry: NATIONS BANK

17. Father's Name (First, Middle, Last): MITCHELL J. MAJKA
18. Mother's Name (First, Middle, Maiden Surname): FRANCES ROMANOWSKI

19a. Informant's Name/Relationship (Type, Print): RAYMOND E. KOWALEWSKI
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2914 DILLON ST. BALTO. MD. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. STANISLAUS CEM. | Date: FEB 20 1999
20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: ▶ Thomas J. Skarda Jr.
22. Name and Address of Facility: SKARDA F.H. 2879 HUDSON ST. BALTO., MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	24 HOURS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. METASTATIC LUNG CANCER	22 MONTHS
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M. Purtell Staff Physician
29c. License number: D19714
29d. Date signed (Month, Day, Year): FEBRUARY 17 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. M. PURTELL, JOHNS HOPKINS BAYVIEW MEDICAL CENTER 4940 EASTERN AVENUE, BALTIMORE, MD 21224

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06116

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANN T. JUSTICE
2. Date of Death (Month, Day, Year): FEBRUARY 24, 1999
3. Time of Death: 4:10 PM
4a. Facility Name (If not institution, give street and number): Berlin Nursing and Rehabilitation Center
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 214 01 2161
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 26,1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8163 Kavanagh Rd.
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress
16b. Kind of Business/Industry: Restaurant
17. Father's Name (First, Middle, Last): John Brezreznski
18. Mother's Name (First, Middle, Maiden Surname): (Unknown)
19a. Informant's Name/Relationship (Type, Print): Barbara L. Smith Flanagan (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 361, Ocean City, MD 21843
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory | Date: 3/1/99
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service License: Stephen D. Lohrmann
22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of): Insulin Dependent Diabetes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D46257
29d. Date signed (Month, Day, Year): 2/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 9714 Heathway Drive Berlin, MD 21811

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 99 06117

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jennie Lea Knox

2. Date of Death (Month, Day, Year): February 18 1999

3. Time of Death: 530A

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 214-12-9868

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 18, 1901

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 300 W. Ring Factory Road

10f. Zip Code: 21014

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unknown

18b. Kind of Business/Industry: Unknown

17. Father's Name (First, Middle, Last): James Shaw

18. Mother's Name (First, Middle, Maiden Surname): Jane Lea

19a. Informant's Name/Relationship (Type, Print): Robert Knox - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6504 Glen Oak Avenue, Baltimore, Maryland 21214

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. gastroenteritis / hemmorhage — Approximate Interval Between Onset and Death: > 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cardiac disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David S. Dunn

29c. License number: D32298

29d. Date signed (Month, Day, Year): February 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID S. DUNN 615 West MacPhail

State Registrar

31. Date filed (Month, Day, Year): FEB 24 1999

32. Registrar's Signature: B. Spaide

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Jennie Knox

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06118

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas James Leek
2. Date of Death: Month February, Day 27, Year 1999
3. Time of Death: 11:45 Am
4a. Facility Name (If not institution, give street and number): St. Elizabeth's Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-10-7054
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/25/1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Arbutus
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1215 Leeds Terrace
10f. Zip Code: 21227
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Shipping
17. Father's Name (First, Middle, Last): Thomas James Leek, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Katie Dash Leek
19a. Informant's Name/Relationship (Type, Print): Henrietta Leek / Spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1215 Leeds Terrace Arbutus Maryland 21227
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery — Date: 3/2/99
20c. Location - City or Town, State: Baltimore, Md.
21. Signature of Funeral Service Licensee: Plant Lukacs
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 21227, 1328 Sulphur Spring Rd. Arbutus, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Carcinoma — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebrovascular accident

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jyotin Parikh MD
29c. License number: D32158
29d. Date signed (Month, Day, Year): 2/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jyotin Parikh, M.D. 821 N. Eutaw Street, Suite 407, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

LEEK, THOMAS

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06119

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVERETTE LEGGINS
2. Date of Death: Month 02 Day 14 Year 99
3. Time of Death: DO 30 AM
4a. Facility Name (If not institution, give street and number): Maryland Transition Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: Unknown
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 38 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-07-60
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 410 E. 25th Street
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: various trades
17. Father's Name (First, Middle, Last): Everette Leggins
18. Mother's Name (First, Middle, Maiden Surname): Margaret Rorie
19a. Informant's Name/Relationship (Type, Print): Debra Leggins
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 509 Archer Street Baltimore, Maryland 21230
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery
Date: 03-02-99
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: WM.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary arrest
Due to (or as a consequence of):
b. Aspiration pneumonia
Due to (or as a consequence of):
c. TB Meningitis
Due to (or as a consequence of):
d. Advanced AIDS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: GETNET E. LUKA [signature]
29c. License number: D0053688
29d. Date signed (Month, Day, Year): 02-14-99

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): GETNET E LUKA 8750 Georgia Ave Apt #604-B

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06120

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCIS LONG
2. Date of Death Month / Day / Year: FEBRUARY 23th, 1999.
3. Time of Death: 4:25 AM
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 565-16-4398
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 8, 1916
9. Birthplace (State or Foreign Country): Utah

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3729 Offutt Road
10f. Zip Code: 21133
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th Grade — College (1-4or 5+): 1+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Goddard Nasa Space Ctr.
17. Father's Name (First, Middle, Last): Roland Long
18. Mother's Name (First, Middle, Maiden Surname): Frances Pate
19a. Informant's Name/Relationship (Type, Print): Mrs. Margaret E. Long - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3729 Offutt Road; Randallstown, Maryland 21133
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorial Park — Date: 2/26/99
20c. Location - City or Town, State: Sykesville, Maryland
21. Signature of Funeral Service Licensee: James F. Hartman Jr.
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA — Approximate Interval Between Onset and Death: 12 Days.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joginder P Mehta M.D.
29c. License number: D41410
29d. Date signed (Month, Day, Year): February 23th, 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER P MEHTA NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133.

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: B. Apple

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06121

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eldona Edith Lishman
2. Date of Death (Month Day Year): FEBRUARY 20, 1999
3. Time of Death: 20:20 PM
4a. Facility Name *(If not institution, give street and number)*: SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-22-0413
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: FEB. 22, 1919
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3913 Bateman Avenue
10f. Zip Code: 21216
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Anthony Bertsavage
18. Mother's Name *(First, Middle, Maiden Surname)*: Rosie Buchauas

19a. Informant's Name/Relationship *(Type, Print)*: James Joseph Lishman (husband)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3913 Bateman Avenue, Baltimore, Maryland 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lake View Memorial Park — Date: Feb.24
20c. Location - City or Town, State: Eldersburg, Maryland

21. Signature of Funeral Service Licensee: John Stark
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. PNEUMONIA	12 DAYS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS

ATRIAL FIBRILLATION

HEPATIC DYSFUNCTION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD
29c. License number: P12333
29d. Date signed *(Month, Day, Year)*: FEBRUARY 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SINAI HOSPITAL OF BALTIMORE JOSEPHINE OWUSU-SAKYI, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 1 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

LISHMAN ELDONA

10

DHMH 16 Rev 6/95

99-0759-510
crp
Hae Min Lee

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06122

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hae Min Lee
2. Date of Death (Month, Day, Year): February 09, 1999
3. Time of Death: 2:00 P.M.
4a. Facility Name *(If not institution, give street and number)*: Leakin Park, 4400 Block of Franklintown Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-53-1661
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 18 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 15, 1980
9. Birthplace *(State or Foreign Country)*: Korea

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7315 Rockridge Road
10f. Zip Code: 21207
10g. Citizen of What Country?: Korea

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesperson
16b. Kind of Business/Industry: Lens Crafters

17. Father's Name *(First, Middle, Last)*: Soon Ki Lee
18. Mother's Name *(First, Middle, Maiden Surname)*: Youn Wha Kim

19a. Informant's Name/Relationship *(Type, Print)*: Youn Wha Kim - Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7315 Rockridge Road; Baltimore, Maryland 21207

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore/Washington Crematory
Date: 2/18/99
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Strangulation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* unknown

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*: unknown
28b. Time of Injury: unknown
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how Injury occurred: Subject found strangled
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Found in wooded area
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Baltimore City Found 4400 Franklintown Road

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: February 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 01 1999
32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

99-0995-510
JOSEPH LAMBERT
ASP

ITEMS: #23 PART I, 27, 28A-F PER MEO G769 3-3-99 WR

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06123

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH ERIC LAMBERT
2. Date of Death: Month FEBRUARY Day 20 Year 1999
3. Time of Death: 5:10 A
4a. Facility Name (If not institution, give street and number): 12 E. GITTINGS ST.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number:
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 41 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/18/57
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12 E. GITTINGS STREET
10f. Zip Code: 21230
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: UNIFORM CO.
17. Father's Name (First, Middle, Last): BILL LAMBERT
18. Mother's Name (First, Middle, Maiden Surname): RUBY HOLYD
19a. Informant's Name/Relationship (Type, Print): MR. JOHN LAMBERT
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1018 S. DECKER AVE. BALTIMORE, MD. 21224
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): OAK LAWN CEME. Date: 2/24/99
20c. Location - City or Town, State: BALTIMORE, MD.
21. Signature of Funeral Service Licensee: Eugene J. Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET STREET BALTIMORE, MD. 21224

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? ☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined

28a. Date of Injury (Month, Day, Year): Found: 2-20-99

28b. Time of Injury: Found: 5:10 A M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND: RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State): 12 E. GITTINGS STREET BALTIMORE, MARYLAND

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wayne Ben Hall

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): FEBRUARY 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MDSeyderm D. Kotte MD 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 8 Per AB Film G768 2-25-99 rja

Certificate of Death

Reg. No. 99 06126

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carson Lee Lank
2. Date of Death (Month, Day, Year): February 17, 1999
3. Time of Death: 2335
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 217-28-4892
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. ~~22~~ 23, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Worcester
10c. City, Town or Location: Newark
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6416 Bowden Road
10f. Zip Code: 21841
10g. Citizen of What Country?: U.S.A.
11. Marital Status: unknown — 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4 or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: unknown
17. Father's Name (First, Middle, Last): William Norman Lank
18. Mother's Name (First, Middle, Maiden Surname): Bertha Lillian Taylor
19a. Informant's Name/Relationship (Type, Print): Gladys Campbell/sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6416 Bowden Road, Newark, Maryland 21841
20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Bltimore, Maryland 21201

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ABDOMINAL AORTIC ANEURYSM & AORTIC STENOSIS
Due to (or as a consequence of):
b. ATHEROSCLEROTIC DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: STAFF SURGEON
29c. License number: D0053551
29d. Date signed (Month, Day, Year): 2/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Todd M.D. 201 Pine Bluff Rd. Salisbury Md.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

CARSON L. LANK 217-28-4892

State Registrar

31. Date filed (Month, Day, Year): FEB 24 1999
32. Registrar's Signature

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06125

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Merriam
2. Date of Death: Month 02 Day 26 Year 99
3. Time of Death: 3P
4a. Facility Name (If not institution, give street and number): Manor Care Towson
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 551-44-5867
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 31, 1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 502 East Joppa Road
10f. Zip Code: 21286
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Robert Barkley
18. Mother's Name (First, Middle, Maiden Surname): Margaret Mateling
19a. Informant's Name/Relationship (Type, Print): Mrs. Gretchen Redden/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Roland Mews Baltimore, Maryland 21210
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Serv. Corp. | Date: 03/01/1999
20c. Location - City or Town, State: Towson, Maryland
21. Signature of Funeral Service Licensee: Stephen D. Coster
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 28a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary artery disease — >2 years
Due to (or as a consequence of):
b. Paget's disease — >2 years
Due to (or as a consequence of):
c. Dehydration — 2 wks
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D42736
29d. Date signed (Month, Day, Year): 2-27-99

30. Name and address of person who completed cause of death Item 23a (Type, Print): 7600 Osler Drive Towson Md 21204

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date Filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06126

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANTHIPPI MELISSARATOS
2. Date of Death (Month, Day, Year): FEBRUARY 26, 1999
3. Time of Death: 3:10 PM
4a. Facility Name (If not institution, give street and number): 5025 EASTERN AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-38-9991
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUGUST 29, 1921
9. Birthplace (State or Foreign Country): RUMANIA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 5025 EASTERN AVENUE
10f. Zip Code: 21224
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PROPRIETOR
16b. Kind of Business/Industry: BAKERY

17. Father's Name (First, Middle, Last): PIPINOS ZANNIKOS
18. Mother's Name (First, Middle, Maiden Surname): DESPINA TSIKOURIA

19a. Informant's Name/Relationship (Type, Print): PANAYIOTIS MELISSARATOS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5025 EASTERN AVENUE BALTIMORE, MARYLAND 21224

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): OAK LAWN CEMETERY | Date: 3/1/99
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Ann S. Matthews
22. Name and Address of Facility: BRADLEY-ASHTON-MATTHEWS FUNERAL HOME, INC. 2134 WILLOW SPRING ROAD BALTIMORE, MARYLAND 21222

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. BRAINSTEM CVA — 7 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RHEUMATOID ARTHRITIS

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Michael A Ankron MD
29c. License number: D46360
29d. Date signed (Month, Day, Year): FEBRUARY 26, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL A ANKRON MD 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE, MD 21224

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: ▶ Renee B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06127

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dora E. Meyers
2. Date of Death (Month Day Year): February 25, 1999
3. Time of Death: 9:00 AM
4a. Facility Name (If not institution, give street and number): 4306 Meadowcliff Road
4b. City, Town, or Location of Death: Long Green
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-32-8983
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 24, 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Long Green
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4306 Meadowcliff Road
10f. Zip Code: 21057
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): C. Elmer Ehrhardt
18. Mother's Name (First, Middle, Maiden Surname): Bertha Amelia Penn
19a. Informant's Name/Relationship (Type, Print): Mr. C. Albert Meyers / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as item 10e.
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Memorial Park
Date: 3/1/99
20c. Location - City or Town, State: Parkville, Maryland
21. Signature of Funeral Service Licensee: Timothy Harman ▶ Timothy S. Harman
22. Name and Address of Facility: Leonard J. Ruck, Inc. Funeral Home, 5305 Harford Road Baltimore, MD 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. STROKE, L. MCA 02/05/99
Due to (or as a consequence of):
b. ASCVD, 20 YEARS
Due to (or as a consequence of):
c. DIABETES, 10 YEARS
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MYASTHENIA GRAVIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Susan Molinaro, MD
29c. License number: D37144
29d. Date signed (Month, Day, Year): 2/26/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN MOLINARO, M.D. 10755 FALLS ROAD, SUITE 200, LUTHERVILLE, MD 21093

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ Irene G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

217-46-1253

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 1 per M.D G-769 3/5/99 reb

Certificate of Death

Reg. No. 99 06128

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~MARY MARCI~~ MARY MACRI
2. Date of Death (Month, Day, Year): February 25, 1999
3. Time of Death: 10:15 pm
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL 1560 LOCH RAVEN
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-46-1253
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): May 9, 1947
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5608 Pioneer Dr.
10f. Zip Code: 21214
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yr's | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Worker
16b. Kind of Business/Industry: Social Security Admin.
17. Father's Name (First, Middle, Last): Joseph Macri
18. Mother's Name (First, Middle, Maiden Surname): Ruth Curran
19a. Informant's Name/Relationship (Type, Print): Salvatore Macri - Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3007 Bayonne Avenue Baltimore, MD 21214
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 3/2/99
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: ▶ Paul L. Hartsock Jr.
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, MD 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Respiratory Failure

Due to (or as a consequence of): b. Chronic Renal Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: P12559
29d. Date signed (Month, Day, Year): February 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Samuel Frimpong, GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD BALTIMORE MD 21239

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06129

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carl Sylvester Muessen
2. Date of Death: Month Feb. Day 25 Year 1999
3. Time of Death: 10:00 PM
4a. Facility Name (If not institution, give street and number): 8613 F Falls Run Road
4b. City, Town, or Location of Death: Ellicott City
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 216-20-6810
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 8, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8613 F Falls Run Road
10f. Zip Code: 21043
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Telephone Engineer
16b. Kind of Business/Industry: Bell Atlantic

17. Father's Name (First, Middle, Last): Joseph W. Muessen, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Anna Laura Baden Hoop

19a. Informant's Name/Relationship (Type, Print): Mr. Joseph Muessen
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 37 Madison Place Apt. 1 Annapolis, MD 21401

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Washington Crem
Date: 3/2/99
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Stephen M Jenkins
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE myocardial infarction — Approximate Interval Between Onset and Death: Acute
Due to (or as a consequence of):
b. Hypertension — yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
prostate cancer

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D-34868
29d. Date signed (Month, Day, Year): March 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dienes, Steve 1105 Lotte Parkway PK Columbia, MD 21044

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature] B. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06130

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carrie May McCulloh
2. Date of Death (Month, Day, Year): FEB. 26, 1999
3. Time of Death: 10:15 P.M.
4a. Facility Name (If not institution, give street and number): 3721 Valley Hill Drive
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 217-22-4116
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 24, 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3721 Valley Hill Drive
10f. Zip Code: 21133
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Schilling George
18. Mother's Name (First, Middle, Maiden Surname): Ida May Brandt

19a. Informant's Name/Relationship (Type, Print): Mrs. Betty Pistel - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3721 Valley Hill Drive; Randallstown, Maryland 21133

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery — Date: 3/2/99
20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. END STAGE HEART DISEASE
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D48189
29d. Date signed (Month, Day, Year): Feb 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACOB M LOVING MD 1425 LIBERTY RD GLENSBURG MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

10

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #7 PER F.H. G769 3-1-99 WR.

Certificate of Death

Reg. No. 99 06131

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARRISON Mosley Sr.
2. Date of Death Month Day Year: February 21 1999
3. Time of Death: 6:25AM
4a. Facility Name (If not institution, give street and number): VA Maryland Health Care System
4b. City, Town, or Location of Death: Perry Point
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 216-24-2736
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 ~~70~~ Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Apr. 3. 1929
9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD
10b. County: Cecil
10c. City, Town or Location: Perry Point
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: VA Maryland Health Care System
10f. Zip Code: 21902
10g. Citizen of What Country? USA

To Be Completed by Funeral Director

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Worker
16b. Kind of Business/Industry: Bethlehem Steel
17. Father's Name (First, Middle, Last): TENNESSEE Mosley
18. Mother's Name (First, Middle, Maiden Surname): NANNIE BLUNTON
19a. Informant's Name/Relationship (Type, Print): Howard Mosley - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4133 Raymond Ave. Balto. Md. 21213
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Kingsmen. Park
Date: 2/27/99
20c. Location - City or Town, State: Randallstown, Md
21. Signature of Funeral Service Licensee: Gale March
22. Name and Address of Facility: March Funeral Home West, Inc. 4300 Wabash Ave. Balto Md. 21215

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Mycardial Infarction — unknown
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D32395
29d. Date signed (Month, Day, Year): 2/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas Finucan, M.D. VA Maryland Health Care System, Perry Point, MD 21902

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

NAME KNOWN TO PHYSICIAN: Mosley, Harrison
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06132

METCALF / CHARLES

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Albert Metcalf, Sr.
2. Date of Death (Month, Day, Year): FEBRUARY 26, 1999
3. Time of Death: 12 30 AM
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice at Mercy
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 219 05 4957
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 17, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 214 S. Smallwood St.
10f. Zip Code: 21223
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Produce Manager
16b. Kind of Business/Industry: Grocery Store

17. Father's Name (First, Middle, Last): George Metcalf
18. Mother's Name (First, Middle, Maiden Surname): Hattie Dorner

19a. Informant's Name/Relationship (Type, Print): Regina Metcalf / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 214 S. Smallwood St., Baltimore, MD 21223

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory | Date: 2/26/99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Stephen D. Lohrmann
22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — unknown
Due to (or as a consequence of):
b. End-Stage Emphysema — unknown
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) STELLA MARIS AT MERCY HOSPICE
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D40854
29d. Date signed (Month, Day, Year): February 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 ST PAUL PLACE, BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item#7 perFHG769 3/1/99 EW

Certificate of Death

Reg. No. 99 06133

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ariosto Mazziotti
2. Date of Death (Month Day Year): February 26, 1999
3. Time of Death: 3:30 AM
4a. Facility Name (If not institution, give street and number): 7624 Lake Glen Drive
4b. City, Town, or Location of Death: Glendale
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-70-2493
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 84 ~~85~~ Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 5,1914
9. Birthplace (State or Foreign Country): Italy

Usual Residence of Decedent

10e. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Glendale
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7624 Lake Glen Drive
10f. Zip Code: 20769
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Elementary; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Stone Mason
16b. Kind of Business/Industry: Construction
17. Father's Name (First, Middle, Last): Massimo Mazziotti
18. Mother's Name (First, Middle, Maiden Surname): Maria Vincenza
19a. Informant's Name/Relationship (Type, Print): Massimo Mazziotti/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13417 Goodtimes Ct. Highland.MD 20777
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery
Date: 3/1/99
20c. Location - City or Town, State: Brentwood,MD
21. Signature of Funeral Service Licensee: ▶ Jam D. Schwartz
22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring,MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. Arteriosclerotic Cerebrialvascular Disease — Approximate Interval Between Onset and Death: 6 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jeremy V. Cooke
29c. License number: D04602
29d. Date signed (Month, Day, Year): 2/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeremy V. Cooke,M.D. 10400 Connecticut Ave. #606 Kensington,MD 20895

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ Anna G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06134

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAURA HELEN MURAWSKI
2. Date of Death (Month, Day, Year): FEB. 26, 1999
3. Time of Death: 7:30PM
4a. Facility Name (If not institution, give street and number): CHURCH HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-09-2392
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/21/07
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4302 SEIDEL AVE.
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 — College (1-4 or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): WALTER BRZOZOWSKI
18. Mother's Name (First, Middle, Maiden Surname): JOSEPHINE BRZOZOWSKI

19a. Informant's Name/Relationship (Type, Print): MR. RAY MURAWSKI
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4412 FINDLAY RD. BALTIMORE, MD. 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HOLY ROSARY CEME. — Date: 3/2/99
20c. Location - City or Town, State: DUNDALK, MD

21. Signature of Funeral Service Licensee: Charles Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ISCHEMIC CARDIOMYOPATHY	WEEKS
Due to (or as a consequence of):	b. ARTERIOSCLEROSIS	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: PNEUMONIA.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A.A. Nazemi MD
29c. License number: D17322
29d. Date signed (Month, Day, Year): FEB 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.A. NAZEMI, M.D. CHURCH HOSPITAL BALT. MD.

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06135

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary A. Murray
2. Date of Death: Month 02 Day 22 Year 99
3. Time of Death: 1530
4a. Facility Name (If not institution, give street and number): Bon Secours Hosp
4b. City, Town, or Location of Death: Balto
4c. County of Death:

Funeral Director

5. Social Security Number: 217-03-6627
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 13 1908
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10e. State: Md.
10b. County:
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1000 N. GILMORE STREET SANDTOWN NURSING HOME
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SELF EMPLOYED
16b. Kind of Business/Industry: SALES PERSON STANLEY PRODUCTS

17. Father's Name (First, Middle, Last): William FOGGIE
18. Mother's Name (First, Middle, Maiden Surname): CLARA THOMPSON

19a. Informant's Name/Relationship (Type, Print): EDYTHE GREGORY
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2551 W. LAFFAYETTE AVE BALT MD. 212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEM. PARK
Date: 2/26/99
20c. Location - City or Town, State: 1101 SULPHUR SPRING RD ARBUTUS

21. Signature of Funeral Service Licensee: Donald E. Glover
22. Name and Address of Facility: DONALD E. GLOVER FUNERAL 1142 N. CARROLLTON AVE BALT MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Pneumonia — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia
Hypothyroid

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M R
29c. License number: D25044
29d. Date signed (Month, Day, Year): 2/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. REGMON MD

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: Ann B. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06136

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID NISBETT
2. Date of Death (Month, Day, Year): FEBRUARY 25, 1999
3. Time of Death: 05:31
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 109-42-0625
6. Sex: 1 ☐ M 2 ☐ F
7. Age (In yrs. last birthday): 46 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07-23-52
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: NY
10b. County: NA
10c. City, Town or Location: Bronx
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No
10e. Street and Number: 1143 219th Street
10f. Zip Code: 10469
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): 7yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attorney
16b. Kind of Business/Industry: Company

17. Father's Name (First, Middle, Last): David Nisbitt
18. Mother's Name (First, Middle, Maiden Surname): Audrey Simon

19a. Informant's Name/Relationship (Type, Print): Johnstone Funeral Chapels
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 East 104th Street New York, NY 10029

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery — Date: 03-03-99
20c. Location - City or Town, State: Bronx, NY

21. Signature of Funeral Service Licensee: Bernard D Johnson
22. Name and Address of Facility: WM.C.MArch FH 1101 E. North Avenue Baltimore, Maryland 21202

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. VENTRICULAR TACHYCARDIA ARREST — 15 MINUTES
Due to (or as a consequence of):
b. ANOXIC BRAIN INJURY — 7 HOURS
Due to (or as a consequence of):
c. ASYSTOLIC CARDIAC ARREST — 7 HOURS
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ASPIRATION OF GASTRIC CONTENTS

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard Vax MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): FEBRUARY 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RICHARD S. VAX, M.D. Johns Hopkins Hospital 600 N. Wolfe Street

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06137

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BARBARA ANNE NESBITT
2. Date of Death (Month, Day, Year): 02-23-99
3. Time of Death: 8:00 AM
4a. Facility Name (If not institution, give street and number): 8107 PLEASANT PLAIN ROAD
4b. City, Town, or Location of Death: N/A
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 158-46-7529
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06-23-53
9. Birthplace (State or Foreign Country): NJ

Usual Residence of Decedent

10a. State: MD
10b. County: ANNE ARUNDEL
10c. City, Town or Location: ODENTON
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 606 MOONGLOW ROAD, APT. #104
10f. Zip Code: 21113
10g. Citizen of What Country?: USA
11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+): 5 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RESERVATION AGENT
16b. Kind of Business/Industry: DELTA - AIRLINE
17. Father's Name (First, Middle, Last): JOSEPH NESBITT
18. Mother's Name (First, Middle, Maiden Surname): FREIDA GREEN
19a. Informant's Name/Relationship (Type, Print): FREIDA NESBITT / MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 145 1ST STREET, ENGLEWOOD, NJ 07631
20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HACKENSACK CEMETERY | Date: 2/27/99
20c. Location - City or Town, State: HACKENSACK, NJ
21. Signature of Funeral Service Licensee: Vaughn C. Greene
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE, 5151 BALTO. NATL' PIKE, BALTO. MD. 21229

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC BREAST CANCER.
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) FRIEND'S HOUSE.

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: MD 018320
29d. Date signed (Month, Day, Year): 2/25/99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Fitzhugh MD. Johns Hopkins Oncology Center Baltimore MD 21287.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: G. Apostol

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06138

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ton Huu Nguyen
2. Date of Death (Month, Day, Year): February 25, 1999
3. Time of Death: 9:14am
4a. Facility Name (If not institution, give street and number): 8608 Flower Ave. #B-5
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 217-45-0759
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): April 28, 1929
9. Birthplace (State or Foreign Country): Vietnam

Usual Residence of Decedent

10a. State: Md
10b. County: Montgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8608 Flower Ave. #B-5
10f. Zip Code: 20912
10g. Citizen of What Country?: Vietnam
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Government Officer
16b. Kind of Business/Industry: Vietnam/Government
17. Father's Name (First, Middle, Last): Bao Van Nguyen
18. Mother's Name (First, Middle, Maiden Surname): Bui Thi Tho
19a. Informant's Name/Relationship (Type, Print): Lai Thi Le (spouse)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8608 Flower Ave. #B-5 Takoma Park, MD 20912
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Crematory
Date: 2-28-99
20c. Location - City or Town, State: Brentwood, Md
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: 11800 New Hampshire Ave. Silver Spring, MD 20904 (Hines-Rinaldi)

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma Lung — Dont
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD ME
29c. License number: D00428
29d. Date signed (Month, Day, Year): Feb 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): IRA N. BRECHER, MD DME 2101 Medical Park Dr Silver Spring MD 20902

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06139

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEO N. NESE
2. Date of Death (Month Day Year): February 24, 1999
3. Time of Death: 6:50am
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-18-8479
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 9/21/22
9. Birthplace (State or Foreign Country): W. Va.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1001 S, ROBINSON STREET
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1942-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SHOP KEEPER
16b. Kind of Business/Industry: RAILROAD

17. Father's Name (First, Middle, Last): SALVATORE NESE
18. Mother's Name (First, Middle, Maiden Surname): FRANCES PONZARO

19a. Informant's Name/Relationship (Type, Print): MR. WALTER STUNDICK
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11207 LYNN DR. KINGSVILLE, MD. 21087

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. STANISLAUS CEME. | Date: 2/27
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Eugene J. [illegible]
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gastrointestinal Bleed — 12 Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Atherosclerotic Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] D.O.
29c. License number: RD 191858
29d. Date signed (Month, Day, Year): February 24 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Eaton Yen 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: [signature] B. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Nese Leo

10+1 WL

DHMH 16 Rev 6/95

WRC
99-0985-510
PHYLIS
OCONNOR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06140

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Phyllis O'Connor
2. Date of Death (Month, Day, Year): FEB. 19, 1999
3. Time of Death: 3:35 PM.
4a. Facility Name (If not institution, give street and number): 1040 DEER RIDGE DR. APT. 402
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A
5. Social Security Number: 483-20-2657
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 11, 1921
9. Birthplace (State or Foreign Country): Iowa

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1040 Deer Ridge Drive
10f. Zip Code: 21210
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 6 Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher
16b. Kind of Business/Industry: School
17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk
19a. Informant's Name/Relationship (Type, Print): Tom Mazur
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2175 Barry Court Easton, PA 18040
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorial Park
Date: 2/26
20c. Location - City or Town, State: Sykesville, Maryland
21. Signature of Funeral Service Licensee: Stephen M Jenkins
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) — e. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? INSPECTION 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cause referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Laron Locke M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): FEB. 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: Irene G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06141

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vincent F Osiecki
2. Date of Death (Month, Day, Year): Feb. 22 99
3. Time of Death: 5:15 Am
4a. Facility Name (If not institution, give street and number): Johns Hopkins Geriatric Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-12-9448
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-21-22
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 304 S. ANN ST.
10f. Zip Code: 21224
10g. Citizen of What Country? USA

To Be Completed by Funeral Director

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINE OPERATOR
16b. Kind of Business/Industry: AARMCO STEEL
17. Father's Name (First, Middle, Last): WILLIAM OSIECKI
18. Mother's Name (First, Middle, Maiden Surname): ANNA SIOJEWSKA
19a. Informant's Name/Relationship (Type, Print): MRS. JEAN PUGH
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9825 HARFORD RD. BALTO, MD 21234
20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. STANISLAUS
Date: 2/24/99
20c. Location - City or Town, State: BALTO., MD
21. Signature of Funeral Service Licensee: Charles Kaczorowski
22. Name and Address of Facility: KACZOROWSKI F.H. 2525 FLEET ST. BALTO, MD 21224

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute MI
Due to (or as a consequence of):
b. Ischemic Bowel
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CAD, type 2DM, chronic a-fib
paraplegia 2° coumadin induced
hemorrhage at T-10

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D Friedman MD
29c. License number: B0053639
29d. Date signed (Month, Day, Year): 2-22-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D Friedman, MD
Johns Hopkins Geriatric Center 5505 Hopkins Bayview Circle Baltimore, MD 21224

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: B. Spaeth

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06142

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GREGORY PRIFTIS
2. Date of Death (Month, Day, Year): FEB. 27 1999
3. Time of Death: 4:10AM
4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-44-7882
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 28, 1908
9. Birthplace *(State or Foreign Country)*: ALBANIA

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11325 SCHUYLKILL RD
10f. Zip Code: 20852
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SELF EMPLOYED/RESTAURANT
16b. Kind of Business/Industry: FOOD SERVICE
17. Father's Name *(First, Middle, Last)*: LEONIDA PRIFTIS
18. Mother's Name *(First, Middle, Maiden Surname)*: KATERINA GIONIS
19a. Informant's Name/Relationship *(Type, Print)*: ELEANOR VEIZIS (DAUGHTER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11325 SCHUYLKILL RD. ROCKVILLE, MD 20852
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GATE OF HEAVEN CEMETERY — Date: 3-3-99
20c. Location - City or Town, State: SILVER SPRING, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: HINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

c. ESOPHAGEAL DIVERTICULAR

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC PULMONARY FIBROSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore Blowke MD
29c. License number: D0052927
29d. Date signed *(Month, Day, Year)*: FEB-27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE LOWBE, HOLY CROSS HOSPITAL, SILVER SPRING, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 1 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06143

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES T. PRAGLOWSKI
2. Date of Death (Month Day Year): FEBRUARY 19, 1999
3. Time of Death: 8:45PM
4a. Facility Name (If not institution, give street and number): 6844 BOSTON AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-18-0109
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/3/23
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6844 BOSTON AVE.
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: HOME
17. Father's Name (First, Middle, Last): JAMES KLEINSMITH
18. Mother's Name (First, Middle, Maiden Surname): BERTHA KIELEK
19a. Informant's Name/Relationship (Type, Print): MRS. JOANNE McEVOY
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6844 BOSTON AVE. BALTIMORE, MD. 21224
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. STANISLAUS CEME. | Date: 2/22/99
20c. Location - City or Town, State: BALTIMORE, MD
21. Signature of Funeral Service Licensee: ▶ Eugene J. Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTIMORE, MD. 21224

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ovarian Cancer - Stage IV — 6 years
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: 027938
29d. Date signed (Month, Day, Year): 2/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mayer Gousotz MD 795 Aquahart Rd. Glen Burnie MD 21061

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06144

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Parks
2. Date of Death (Month, Day, Year): February 12, 1999
3. Time of Death: 1:40 PM
4a. Facility Name (If not institution, give street and number): Gladys Spellman Nursing Home
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Hyattsville

Funeral Director

5. Social Security Number: 213-12-1034
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 21, 1920
9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: Maryland
10b. County: Hyattsville
10c. City, Town or Location: Cheverly
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2900 Mercy Lane
10f. Zip Code: 20784
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? unknown 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown — College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown
17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): unknown
19a. Informant's Name/Relationship (Type, Print): Betty Parks
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6019 Parkland Avenue, Forestville, Maryland
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place) — Date — 20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Louis Steinberg MD
29c. License number: D12015
29d. Date signed (Month, Day, Year): 2-13-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Louis Steinberg 6492 Landover Rd, Landover, MD 20785

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 24 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06145

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALDEN J. L. ROBERTS
2. Date of Death (Month, Day, Year): FEBRUARY 25, 1999
3. Time of Death: 3:00am
4a. Facility Name (If not institution, give street and number): 731 SPRINGFIELD AVENUE (res.)
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-34-3989
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08/16/1938
9. Birthplace (State or Foreign Country): S. Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 731 SPRINGFIELD AVENUE
10f. Zip Code: 21212
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: A. Franks

17. Father's Name (First, Middle, Last): Larman Roberts
18. Mother's Name (First, Middle, Maiden Surname): Omelia Jackson

19a. Informant's Name/Relationship (Type, Print): Omelia Roberts
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3333 Alto Road, Baltimore, MD 21216

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet. Cem. — Date: 3/3/99
20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: ▶ Leroy O. Dyett
22. Name and Address of Facility: LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD 21207

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. ATHEROSCLEROTIC HEART DISEASE — YEARS
Due to (or as a consequence of):
c. DIABETES MELLITUS — 26 YEARS
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
END STAGE RENAL DISEASE
HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Jose S. Almario MD
29c. License number: D47051
29d. Date signed (Month, Day, Year): 3/1/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSE S. ALMARIO 6565 N. CHARLES ST #216 BALT. MD 21204

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ Jeanne B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 8 Per FH Film G769 3-1-99 rja

Certificate of Death

Reg. No. 99 06146

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALLEN REED
2. Date of Death: Month February Day 23 Year 99
3. Time of Death: 7:40PM
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-18-9541
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): ~~9-8-24~~ 9-8-24
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5317 Cordelia Avenue
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MECHANIC
16b. Kind of Business/Industry: Firestone Tire Co.

17. Father's Name (First, Middle, Last): BERNARD REED, SR.
18. Mother's Name (First, Middle, Maiden Surname): BERTHA LOVING

19a. Informant's Name/Relationship (Type, Print): Esther Harris / Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2838 Virginia Ave Baltimore, Md 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): David Ridge Cemetery | Date: 2-27-99
20c. Location - City or Town, State: Reisterstown, Md
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Chatman - Harris Funeral Home, 5240 Reisterstown Road, Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPTICEMIA	1 DAY
Due to (or as a consequence of):	b. PNEUMONIA	4 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: AT2438946
29d. Date signed (Month, Day, Year): 2/23/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SONAL SETHI, UNION MEMORIAL HOSPITAL, 201, UNIVERSITY PARKWAY, BALTIMORE - 21212

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit page.

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06147

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY VIRGINIA REED
2. Date of Death: Month February Day 25 Year 99
3. Time of Death: 10:35 pm
4a. Facility Name (If not institution, give street and number): GENESIS CROMWELL ELDERCARE
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-09-5820
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/24/17
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1825 LOCH SHIEL ROAD
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE | College (1-4 or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): WALTER TALBOTT RUSSELL
18. Mother's Name (First, Middle, Maiden Surname): MARY ROSALIE HOOVER

19a. Informant's Name/Relationship (Type, Print): MARY REED DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1825 LOCH SHIEL ROAD BALTIMORE, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): DULANEY VALLEY MEM. GAR. | Date: 3/1/99
20c. Location - City or Town, State: COCKEYSVILLE, MD

21. Signature of Funeral Service Licensee: ▶ Heather N. Hay
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Mary Reed

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Tymphoma — one y.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Marin Kowalowicz MD
29c. License number: D21022
29d. Date signed (Month, Day, Year): 2-26-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. KOWALOWICZ 8114 SANDPIPER CIRCLE BALTO MD 21236

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06148

Certificate of Death

Amended#1 perPhyG769 3/11/99 FW

Reg. No.

2:49 PM

Tressa Snyder 2/23/99

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tressa ~~May~~ Mae Snyder
2. Date of Death (Month, Day, Year): February 23,1999
3. Time of Death: 2:49 PM
4a. Facility Name (If not institution, give street and number): Gilchrist Center for Hospice Care Ctr.
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-28-1549
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 16,1910
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Colgate
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7835 Gough Street
10f. Zip Code: 21224
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 Years | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Service Clerk
18b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Howard Myers
18. Mother's Name (First, Middle, Maiden Surname): Rosa Cook

19a. Informant's Name/Relationship (Type, Print): Mr. Wayne L. Snyder/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8709 Richmond Ave. Baltimore, Maryland 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Barrens Un. Luth. Church Cem.
Date: 2/26/99
20c. Location - City or Town, State: Franklintown, PA

21. Signature of Funeral Service Licensee: ▶ Johnny L. Duda
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. renal failure — 4 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Date of Injury (Month, Day Year)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ W. Anthony Riley, MD
29c. License number: D25225
29d. Date signed (Month, Day, Year): February 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06149

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GWENDOLYN JOHANNA SHARP
2. Date of Death: Month February Day 26 Year 1999
3. Time of Death: 1:25 AM
4a. Facility Name (If not institution, give street and number): MARYLAND GENERAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-07-0448
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/30/12
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: TOWSON
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1000 EAST JOPPA ROAD APT. 513
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): CHARLES BERKEMEIER
18. Mother's Name (First, Middle, Maiden Surname): LILLIAN LUSBY

19a. Informant's Name/Relationship (Type, Print): ROBERT S. SHARP HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1000 E. JOPPA ROAD APT. 513 TOWSON, MD 21286

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY, INC.
Date: 2/27/99
20c. Location - City or Town, State: CATONSVILLE, MD

21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Respiratory Failure

Due to (or as a consequence of): b. Cardiac Arrhythmia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes, Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Nsekenene Kolongo
29c. License number: P 09506
29d. Date signed (Month, Day, Year): 2/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NSekenene Kolongo, M.D. c/o Maryland General Hospital.

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: ▶ Bernice B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06150

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN THOMAS SMITH SR.
2. Date of Death: Month FEBRUARY Day 26 Year 1999
3. Time of Death: 1:45 PM
4a. Facility Name (If not institution, give street and number): 514 CHURCH STREET
4b. City, Town, or Location of Death: BROOKLYN PARK
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 212-07-7777
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 11, 1915
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: BROOKLYN PARK
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 514 CHURCH STREET
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LONG SHORMAN
16b. Kind of Business/Industry: STEAMSHIP TRADE
17. Father's Name (First, Middle, Last): STANLEY SMITH
18. Mother's Name (First, Middle, Maiden Surname): STEPHANIE PATCIENSKA
19a. Informant's Name/Relationship (Type, Print): MARIE MADELYN SMITH (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 514 CHURCH STREET, BROOKLYN PARK, MD. 21225
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GLEN HAVEN MEMORIAL PARK
Date: 3/1/99
20c. Location - City or Town, State: GLEN BURNIE, MD.
21. Signature of Funeral Service Licensee: Michael C. Sa[illegible]
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. BRAIN METASTASIS
Due to (or as a consequence of):
b. LUNG CANCER (ADENOCARCINOMA)
Due to (or as a consequence of):
c. ASBESTOSIS
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ATRIAL FIBRILLATION / FLUTTER

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Orn Elinsson
29c. License number: 031076
29d. Date signed (Month, Day, Year): 3/1/1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ORN ELINSSON M.D. 6830 HOSPITAL DR., BALTO, MD 21237

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: B. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06151

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David George Savage, Sr.
2. Date of Death: Month February Day 26 Year 1999
3. Time of Death: 4:11 PM
4a. Facility Name (If not institution, give street and number): Doctors Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 216-40-8825
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 3, 1943
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Brandywine
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 14211 South Springfield Road
10f. Zip Code: 20613
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) Grade 10 | College (1-4 or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner
16b. Kind of Business/Industry: Construction Co.

17. Father's Name (First, Middle, Last): George Franklin Savage
18. Mother's Name (First, Middle, Maiden Surname): Mabel Lutholtz

19a. Informant's Name/Relationship (Type, Print): David Savage, Jr. / son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8011 Cross Creek Drive Glen Burnie, Md. 21061

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: Feb 27, 1999
20c. Location - City or Town, State: Catonsville, Md.

21. Signature of Funeral Service Licensee: ▶ Greg S. Kay
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707-4389

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. MULTIPLE MYELOMA — Approximate Interval Between Onset and Death: YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jutcovich
29c. License number: D31089
29d. Date signed (Month, Day, Year): February 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MORRIS JUTCOVICH, MD 8201 Corporate Drive, Suite 620 LANDOVER, MD 20785

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ Joyce B. Sparks

SAVAGE, DAVID

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06152

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mabel Lee Stanfill
2. Date of Death: Month FEBRUARY Day 22 Year 1999
3. Time of Death: 10:15 Pm
4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 559-18-9591
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 7, 1909
9. Birthplace *(State or Foreign Country)*: Albemarie, NC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Jessup
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2103 Montevideo Road
10f. Zip Code: 20794
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Roller Shop Worker
16b. Kind of Business/Industry: Mill Company

17. Father's Name *(First, Middle, Last)*: Joel Reid Doby
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Ethel Harrington

19a. Informant's Name/Relationship *(Type, Print)*: Clyde Way (Nephew)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2103 Montevideo Road Jessup, Maryland 20794

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fairview Memorial Park; Date: 2/26 1999
20c. Location - City or Town, Stete: Albemarle, NC

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Fecility: Singleton Funeral Home PA, 1 Second Avenue S.W. Glen Burnie, Maryland 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth)
a. SEPSIS
Due to (or as a consequence of):
b. LOBAR PNEUMONIA
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☑ No

25. Wes cese referred to medicel examiner? 1☐ Yes 2☑ No
26. Piece of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D45149
29d. Date signed *(Month, Day, Year)*: FEBRUARY 22 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ONABAJO 301 HOSPITAL DRIVE GLEN BURNIE MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 01 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 1 Per PHY FilmG769 3-1-99 rja

Certificate of Death

Reg. No. 99 06153

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~VIRGINIUS~~ VIRGINUS LEE SAUNDERS, JR.
2. Date of Death (Month Day Year): February 10, 1999
3. Time of Death: 9:00 PM
4a. Facility Name (If not institution, give street and number): 12617 KEMBRIDGE DR
4b. City, Town, or Location of Death: BOWIE
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577077969
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9/18/08
9. Birthplace (State or Foreign Country): USA

Usual Residence of Decedent

10a. State: MD
10b. County: PRINCE GEORGES
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 12617 Kembridge Drive
10f. Zip Code: 20715
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Contractor

17. Father's Name (First, Middle, Last): Viriginius Lee Saunders, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Jessie Wood

19a. Informant's Name/Relationship (Type, Print): Mary Saunders/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12617 Kembridge Drive,Bowie, Maryland 20715

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) | Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary arrest 2 to
Due to (or as a consequence of):
b. Metastatic Carcinoma of Bladder — 2 yrs
Due to (or as a consequence of):
c. CAD & Angina CHF — 10 yrs
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D18480
29d. Date signed (Month, Day, Year): 2/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RONALD C. SROKA, M.D. 1684 VILLAGE GREEN, CROFTON MD 21114

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06154

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Matlide Mancilla Serranos
2. Date of Death Month Day Year: February 24,1999
3. Time of Death: 1:15 P.M.
4e Facility Name *(If not institution, give street and number)*: 1112 Hawlings Road
4b. City, Town, or Location of Death: Brookeview
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-48-4515
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JUN. 16, 1909
9. Birthplace *(State or Foreign Country)*: GUATEMALA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: BROOKEVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1112 HAWLINGS ROAD
10f. Zip Code: 20833
10g. Citizen of What Country?: GUATEMALA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 3rd; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEKEEPER
16b. Kind of Business/Industry: DOMESTIC

17. Father's Name *(First, Middle, Last)*: IGNACIO SERRANOS
18. Mother's Name *(First, Middle, Maiden Surname)*: CLARA MANCILLA

19a. Informant's Name/Relationship *(Type, Print)*: NORMA JONES (DAUGHTER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1112 HAWLINGS ROAD BROOKEVILLE MARYLAND 20833

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GATE OF HEAVEN CEMETERY
Date: MAR.01, 1999
20c. Location - City or Town, State: SILVER SPRING MARYLAND

21. Signature of Funeral Service Licensee: ▶ James B. Schwartz
22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring,MD 20904

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. CEREBROVASCULAR ACCIDENT — Approximate Interval Between Onset and Death: 12 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ORGANIC DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D18726
29d. Date signed *(Month, Day, Year)*: FEBRUARY 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ARTHUR SCHOENGOLD, M.D., 18111 PRINCE PHILLIP DRIVE OLNEY MARYLAND 20832-1513

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 1 1999
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 06155

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Katherine Szalecki
2. Date of Death (Month, Day, Year): Feb 27 1999
3. Time of Death: 1000 am
4a. Facility Name (If not institution, give street and number): Pikesville Nursing Home
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-30-5773
6. Sex: 1 ☐ M 2 ☑ F
7. Age (In yrs. last birthday): 65 Yrs. (If Under 1 Year: Months, Days; If Under 24 Hrs.: Hours, Min.)
8. Date of Birth (Month, Day, Year): 2-23-1933
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9207 Bengal Road
10f. Zip Code: 21133
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Kernan Hospital

17. Father's Name (First, Middle, Last): Richard E. Holbert
18. Mother's Name (First, Middle, Maiden Surname): Thelma Ditto

19a. Informant's Name/Relationship (Type, Print): Joseph H. Szalecki Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9207 Bengal Road Randallstown MD 21133

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation Service
Date: 2-28-99
20c. Location - City or Town, State: Hamstead MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Chronic Obstructive Lung Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: 029085
29d. Date signed (Month, Day, Year): Feb 27 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen J. Chacus M.D. 5310 Old Court Rd 21133

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06156

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tara MacKenzie Trimble
2. Date of Death (Month, Day, Year): February 26 1999
3. Time of Death: 1 00 AM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: N/A
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours 1 Min. 9
8. Date of Birth (Month, Day, Year): Feb. 25, 1999
9. Birthplace (State or Foreign Country): Baltimore, Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4224 Thorncliff Road
10f. Zip Code: 21236
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dependent - Prematurity
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Thomas M. Trimble Jr.
18. Mother's Name (First, Middle, Maiden Surname): Denise L. Economos-Famelis

19a. Informant's Name/Relationship (Type, Print): Thomas M. Trimble Jr. (Father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4224 Thorncliff Road Baltimore, Md. 21236

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. — Date: 3/1/99
20c. Location - City or Town, State: Towson Maryland

21. Signature of Funeral Service Licensee: Milton J. Knight Jr — Milton J. Knight Jr
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Prematurity — 1 hour 9 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: RD 187335
29d. Date signed (Month, Day, Year): 2/26/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Francine McLeod MD 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Tara Economos-Famelis, Babygirl

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06157

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN TEMPLE
2. Date of Death: Month FEBRUARY Day 25 Year 1999
3. Time of Death: 2-10am
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-03-0896
6. Sex: ☑ 1 M ☐ 2 F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 29, 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: ☒ 1 Yes ☐ 2 No
10e. Street and Number: 3837 Ravenwood Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.
11. Marital Status: ☐ 1 Never Married ☒ 2 Married ☐ 3 Widowed ☐ 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☒ 1 Yes ☐ 2 No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ 1 Yes ☒ 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yr's — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver
16b. Kind of Business/Industry: Sealtest Foods
17. Father's Name (First, Middle, Last): George Temple
18. Mother's Name (First, Middle, Maiden Surname): Emma Yeager
19a. Informant's Name/Relationship (Type, Print): Mrs. Anna M. Temple - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3837 Ravenwood Avenue Baltimore, MD 21213
20a. Method of Disposition: ☒ 1 Burial ☐ 2 Cremation ☐ 3 Removal from State ☐ 4 Donation ☐ 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery — Date: 3/1/99
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, MD 21214

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. SEPSIS
Due to (or as a consequence of):
b. PNEUMONIA
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

CORONARY ARTERY DISEASE

CARDIOMYOPATHY

23b. Did tobacco use contribute to the cause of death? ☑ 1 Yes ☐ 2 No ☐ 3 Probably ☐ 4 Unknown

24a. Was an autopsy performed? ☐ 1 Yes ☑ 2 No

24b. Were autopsy findings available prior to completion of cause of death? ☐ 1 Yes ☑ 2 No

25. Was case referred to medical examiner? ☐ 1 Yes ☑ 2 No

26. Place of Death (Check only one): Hospital: ☑ 1 Inpatient ☐ 2 ER/Outpatient ☐ 3 DOA — Other: ☐ 4 Nursing Home ☐ 5 Residence ☐ 6 Other (Specify)

27. Manner of Death: ☑ 1 Natural ☐ 2 Accident ☐ 3 Suicide ☐ 4 Homicide ☐ 5 Pending investigation ☐ 6 Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? ☐ 1 Yes ☐ 2 No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): ☑ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] RESIDENT
29c. License number: AT-243 2934-506
29d. Date signed (Month, Day, Year): FEBRUARY 25 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. GABA, DEPT. OF MEDICINE, GOOD SAMARITAN HOSPITAL, BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 7 Per AB FilmG769 3-1-99 rja

Certificate of Death

Reg. No. 99 06158

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lloyd Turney
2. Date of Death (Month, Day, Year): Feb 14 1999
3. Time of Death: 6:15PM
4a. Facility Name (If not institution, give street and number): Union Rescue MIssion
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 219 46 0608
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 19 1935
9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: unknown
10f. Zip Code: unknown
10g. Citizen of What Country? U.S.A.
11. Marital Status: unknown — 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? unknown — 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown
17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): unknown
19a. Informant's Name/Relationship (Type, Print): unknown
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrythemia — Approximate Interval Between Onset and Death: sudden
Due to (or as a consequence of):
Arteriosclerotic heart disease — Uk yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) MIssion
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dpty Med Ex
29c. License number: D 09157
29d. Date signed (Month, Day, Year): Feb 14 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Snow, M.D. 124 w 3rd st Cumb Md 21502

To Be Completed by Physician/Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 06159

Amended Item#5 perInf G772 6/22/99 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JANET UNGER
2. Date of Death (Month, Day, Year): FEBRUARY 22,99
3. Time of Death: 8:30AM
4a. Facility Name (If not Institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-14-2389 ~~097-12-8903~~
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 2,1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8810 Greens Lane
10f. Zip Code: 21133
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Edwin Ellswin Grain
18. Mother's Name (First, Middle, Maiden Surname): Viola Estelle Seidenstricker
19a. Informant's Name/Relationship (Type, Print): Carl Fred Unger (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8810 Greens Lane, Randallstown, Maryland 21133
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore/Washington Crematory
Date: FEB.23
20c. Location - City or Town, State: Laurel, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, Maryland 21133

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. LUNG CANCER — 2 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ANGINA

HYPOTHYROIDISM

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K.S.RAO.M.D

29c. License number: D43462

29d. Date signed (Month, Day, Year): FEBRUARY 22,99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K.S.RAO.M.D. NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 06160

ITEM: #7 PER F.H. G769 3-1-99 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Fania Vosko
2. Date of Death: Month 02 Day 16 Year 99
3. Time of Death: 4:40p
4a. Facility Name (If not institution, give street and number): Hopkins Bayview
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-27-9381
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 73 74 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9-25-25
9. Birthplace (State or Foreign Country): Ukraine

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 629 N. Highland Ave.
10f. Zip Code: 21224
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 8 College (1-4 or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home
17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Unknown
19a. Informant's Name/Relationship (Type, Print): Comm. on Aging
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1000 Cathedral St. 3rd Fl. Balto, MD 21201
20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): First United Evangelical
Date: 2/24/99
20c. Location - City or Town, State: Balto., MD
21. Signature of Funeral Service Licensee: Charles Kacyorowski
22. Name and Address of Facility: Kalzorowski FH 2525 Fleet St. Balto, MD 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Uremia

Due to (or as a consequence of):
b. Congestive heart failure

Due to (or as a consequence of):
c. Atrial fibrillation

Due to (or as a consequence of):
d. Renal failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes
CAD
Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Fania Caplan M.D.
29c. License number: D0051156
29d. Date signed (Month, Day, Year): 02/17/99.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Fania V. Caplan M.D. Johns Hopkins Bayview Geriatrics Center

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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WRC
99-0266-510
RAYMOND
VAHLROUS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, II, 27 PER MEO G769 3-5-99 WR.

Certificate of Death

Reg. No. 99 06161

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond Vahlrous
2. Date of Death (Month Day Year): JANUARY 17, 1999
3. Time of Death: 9:30 P.M.
4a. Facility Name (If not institution, give street and number): 100 WATER ST.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 138-46-7581
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 47 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 25, 1951
9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: Homeless
10f. Zip Code: N/A
10g. Citizen of What Country? USA

11. Marital Status: unknown — 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: unknown
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Off. Sinclair-Anderson, 1C12
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 601 E. Fayette St., Balto., Maryland 21202

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC ALCOHOLISM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JANUARY 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 24 1999
32. Registrar's Signature

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06162

WALTER, JULIUS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JULIUS GEORGE WALTER
2. Date of Death (Month Day Year): FEBRUARY 26, 1999
3. Time of Death: 10:20AM
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-09-2381-A
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 29, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 36 Springtown Circle
10f. Zip Code: 21234
10g. Citizen of What Country? United States
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Unknown
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Courier
16b. Kind of Business/Industry: Messenger Service
17. Father's Name (First, Middle, Last): Audolf Walter
18. Mother's Name (First, Middle, Maiden Surname): Mary Haigis
19a. Informant's Name/Relationship (Type, Print): Mrs. Helen Walter/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 36 Springtown Circle Baltimore, Maryland 21234
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Mausoleum
Date: 03/01/99
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Stephen Coster
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Ruptured aortic aneurysm — unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malignant Hypertension
Addison's disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Timothy C Herlihy
29c. License number: D32639
29d. Date signed (Month, Day, Year): 2-26-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TIMOTHY HERLIHY, M.D. 660 KENILWORTH DR; BALTO, MD 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5+1

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: P. Sparks

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06163

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Russell Ignatius Wooden
2. Date of Death (Month, Day, Year): February 26, 1999
3. Time of Death: 5:15 AM
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 215-24-5492
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 12, 1930
9. Birthplace (State or Foreign Country): Baltimore, Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford Co.
10c. City, Town or Location: Fallston
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1507 Wildwood Drive
10f. Zip Code: 21047
10g. Citizen of What Country?: United States of America

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korean Conflict
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 08 | College (1-4 or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Stationary Engineer
16b. Kind of Business/Industry: Seagrams Distillery

17. Father's Name (First, Middle, Last): Thomas Wooden
18. Mother's Name (First, Middle, Maiden Surname): Mary Bridget Brown

19a. Informant's Name/Relationship (Type, Print): (Wife) Mrs. Mary Sidney (nee Miller) Wooden
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1507 Wildwood Drive Fallston, Maryland 21047

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gardens | Date: 3/01/99
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair — Jeffrey L. Gair
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): e. pancreatic cancer — Approximate Interval Between Onset and Death: 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. A. Riley
29c. License number: D25205
29d. Date signed (Month, Day, Year): February 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W A Riley GBMC 6701 N. Charles St Balto, MD 21204

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Russell Wooden February 26, 1999 5:15 am

12+1

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 7 Per FH Film G769 3-1-99 rja

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06164

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William T. Walton
2. Date of Death (Month, Day, Year): February 22, 1999
3. Time of Death: 9:40 P.M.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-18-5490
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 ~~81~~ Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 10, 1917
9. Birthplace (State or Foreign Country): Nicaragua

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8620 Kelso Drive
10f. Zip Code: 21221
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Infantry
16b. Kind of Business/Industry: Army
17. Father's Name (First, Middle, Last): William J.M. Walton
18. Mother's Name (First, Middle, Maiden Surname): Alice C. Rouiz
19a. Informant's Name/Relationship (Type, Print): Grace Walton / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8620 Kelso Drive, Balto. Md. 21221
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balto.-Wash. Crematory
Date: 2-25-99
20c. Location - City or Town, State: Laurel Md.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bradley-Ashton-Matthews Funeral Home, Inc 2134 Willow Spring Rd., Balto., Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	2 DAYS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Pneumonia	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease, Hypertension Cerebrovascular Accident, Parkinson's Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Erik A. Eways
29c. License number: 050228
29d. Date signed (Month, Day, Year): 2/22/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Erik Eways 9000 Franklin Square Dr. Baltimore, Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

William Walton

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06165

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carrie B. Williams
2. Date of Death (Month, Day, Year): February 26, 1999
3. Time of Death: 6:00pm
4a. Facility Name (If not institution, give street and number): 2903 Thorndale Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 229-34-4553
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 11, 1930
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2903 Thorndale Avenue
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laundress
16b. Kind of Business/Industry: Cleaners

17. Father's Name (First, Middle, Last): Lawrence Ellis
18. Mother's Name (First, Middle, Maiden Surname): Pearl Gee

19a. Informant's Name/Relationship (Type, Print): James Williams (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2903 Thorndale Avenue Baltimore, Maryland 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet Cem
Date: 3/1/99
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Caple Funeral Service 5502 Winner Avenue Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic ca bladder

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gail W. Miller, MD
29c. License number: D22719
29d. Date signed (Month, Day, Year): 3/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gail W. Miller, MD, 1205 York Rd, Suite 38, Lutherville, MD

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 05166

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francis X. Windfelder
2. Date of Death: Month February Day 25 Year 99
3. Time of Death: 9 am
4a. Facility Name (If not institution, give street and number): 1416 Woodcliff Ave.
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-16-3297
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 11, 1917
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10e. State: MD. | 10b. County: Baltimore | 10c. City, Town or Location: Catonsville | 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1416 Woodcliff Ave. | 10f. Zip Code: 21228 | 10g. Citizen of What Country?: U.S.A.

To Be Completed by Funeral Director

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postman
16b. Kind of Business/Industry: Federal Gov.
17. Father's Name (First, Middle, Last): George Windfelder
18. Mother's Name (First, Middle, Maiden Surname): Sophia Kaltenbach
19a. Informant's Name/Relationship (Type, Print): Claire Ramirez
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8418 Ivy Dr. Ellicott City, MD 21043
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): New Cath. Cem. | Date: Feb. 27 1999
20c. Location - City or Town, State: Baltimore, MD.
21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.
22. Name and Address of Facility: Skarda F.H. 2829 Hudson St. Baltimore, MD. 21224

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Stroke — Approximate Interval Between Onset and Death: Sudden

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Previous stroke / Hypertension, Atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Raafat Y. G.
29c. License number: D31724
29d. Date signed (Month, Day, Year): 2/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAAFAT Y. GIRGIS 114 Maidenchoice LA.

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS #26 PER MD G769 3-1-99 WR.

Certificate of Death

Reg. No. 99 06167

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joan M. Winston
2. Date of Death (Month, Day, Year): Feb. 10 1999
3. Time of Death: 2:45pm
4a. Facility Name (If not institution, give street and number): 1504 Phoenix Road
4b. City, Town, or Location of Death: Phoenix
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 178-22-8912
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 20 1928
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: FL
10b. County: Collier
10c. City, Town or Location: Naples
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 733 Wiggins Lake Drive, Unit 101
10f. Zip Code: 34110
10g. Citizen of What Country?: USA

11. Meritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Oliver Heistand
18. Mother's Name (First, Middle, Maiden Surname): Helen C. Lowe

19a. Informant's Name/Relationship (Type, Print): H. William Winston/husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 733 Wiggins Lake Dr., Unit 101, Naples, FL 34110

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Rose Cemetery — Date: 2/13/99
20c. Location - City or Town, State: York, PA

21. Signature of Funeral Service Licensee: Bryan W. Clary
22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Ovarian Cancer — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) DAUGHTER'S RESIDENCE

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Deborah K. Armstrong
29c. License number: D36986
29d. Date signed (Month, Day, Year): February 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Deborah Armstrong, M.D. 600 N. Wolfe St., Balto., MD 21287

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: Steve B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 31 Per AB FilmG769 3-1-99 rja

Certificate of Death

Reg. No. 99 06168

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Wallace
2. Date of Death (Month Day Year): Feb. 13, 1999
3. Time of Death: 1:17 pm
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital Center
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 217-26-0576
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 10, 1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Lothian
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5939 Talbott Road
10f. Zip Code: 20711
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? unknown 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown
17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): unknown
19a. Informant's Name/Relationship (Type, Print): unknown
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street, Baltimore, Maryland 21201

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Empyema Thoracis with Bronchopleural fistula
Due to (or as a consequence of):
b. Severe Chronic obstructive lung disease
Due to (or as a consequence of):
c. Severe pulmonary hypertension
Due to (or as a consequence of):
d. Ruptured Pulmonary Blebs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Recent Pulmonary Embolism

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: James Tseng MD
29c. License number: MD-42082
29d. Date signed (Month, Day, Year): February 13, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES S. TZENG, MD, 7501 Surratts Rd. #303, Clinton, MD 20735

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): February 13, 1999
32. Registrar's Signature: MAR 1 1999 Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06169

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kenneth S. Woodring
2. Date of Death (Month, Day, Year): February 22, 1999
3. Time of Death: 10:20 AM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-09-5427
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 12, 1912
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 15400 Bassett Ln, #3G
10f. Zip Code: 20906
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pastor
16b. Kind of Business/Industry: Ministry
17. Father's Name (First, Middle, Last): William W. Woodring
18. Mother's Name (First, Middle, Maiden Surname): Lillian Sharp
19a. Informant's Name/Relationship (Type, Print): Mildred Woodring/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15400 Bassett Ln, #3G, Silver Spring, MD 20906
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: Feb 25
20c. Location - City or Town, State: Brentwood, MD
21. Signature of Funeral Service Licensee: ▶ Alan J. Donnell
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SUDDEN CARDIAC DEATH — Minutes

Due to (or as a consequence of)
b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):
c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
INTERSTITIAL LUNG DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D38457
29d. Date signed (Month, Day, Year): FEBRUARY 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Nakul Goyal, 18101 Prince Phillip Dr, Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: ▶ Anne B. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

99-0946-025
jhm
DARRYL
WATSON

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06170

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Darryl Watson
2. Date of Death (Month, Day, Year): FEBRUARY 18, 1999
3. Time of Death: 08:00
4a. Facility Name (If not institution, give street and number): HARFORD MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 578-70-1554
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7-12-53
9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 2469 Woodbrook Ave
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Construction
17. Father's Name (First, Middle, Last): Hizzie P. Williams
18. Mother's Name (First, Middle, Maiden Surname): Carolyn Watson
19a. Informant's Name/Relationship (Type, Print): Cynthia Chainey Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2469 Woodbrook Ave Baltimore, MD. 21217
20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet. | Date: 3-1-99
20c. Location - City or Town, State: Owings Mills, MD.
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Albert P. Wylie F/H PA 638 N. Gilmor Street Baltimore, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): 2/18/99
28b. Time of Injury: 706 AM
28c. Injury at Work? 1 ☐ Yes 2 ☑ No
28d. Describe how injury occurred: motor vehicle collision
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): street
28f. Location (Street and Number or Rural Route Number, City or Town, State): Rts 40 & 7 Havre de Grace, Md

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dennis J. Chute MD
29c. License number: OCME
29d. Date signed (Month, Day, Year): FEBRUARY 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 22 Per A.B. 3-1-99 FilmG769 rja

Certificate of Death

Reg. No. 99 06171

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert YOUNG
2. Date of Death: Month 02 Day 07 Year 99
3. Time of Death: 1349
4a. Facility Name (If not institution, give street and number): University of Maryland Medical System
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: unknown
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): unknown Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): unknown
9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: unknown
10b. County: unknown
10c. City, Town or Location: unknown
10d. Inside City Limits: unknown 1 [ ] Yes 2 [ ] No
10e. Street and Number: unknown
10f. Zip Code: unknown
10g. Citizen of What Country?: unknown

11. Marital Status: unknown 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? unknown 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): unknown
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy ~~Bord,~~ Board, 655 W. Baltimore Street, Baltimore, Maryland 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial infarction
Due to (or as a consequence of):
b. Hypertension
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carol Ann Markson
29c. License number: P10276
29d. Date signed (Month, Day, Year): 02/07/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 1 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06172

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph F. Yurek
2. Date of Death: Month February Day 20 Year 1999
3. Time of Death: 14:24
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-30-4484
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 66 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/10/32
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1001 S. BELNORD AVE.
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1953-1955
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FIREFIGHTER
16b. Kind of Business/Industry: BALTIMORE CITY
17. Father's Name (First, Middle, Last): JOSEPH W. YUREK
18. Mother's Name (First, Middle, Maiden Surname): SELMA MARSZELKIEWICZ
19a. Informant's Name/Relationship (Type, Print): MRS. THERESA YUREK
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1900 CHURCH RD. BALTIMORE, MD. 21222
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD. V.A. CEME.CROWNS. Date: 2/23
20c. Location - City or Town, State: CROWNSVILLE, MD.
21. Signature of Funeral Service Licensee: Eugene J. Cartof
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — Approximate Interval Between Onset and Death: 2 weeks
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease
Disseminated Prostate Cancer

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dorothy L. Chung
29c. License number: RES-001
29d. Date signed (Month, Day, Year): February 20, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4940 Eastern Avenue Baltimore, MD 21224

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: B. Apostle

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

ITEM: #2 PER MD G769 3-24-99 WR.

Certificate of Death

Reg. No. 99 06173

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FREDERICK JOSEPH YENNI
2. Date of Death: Month February Day 17 Year 1999
3. Time of Death: 10:40 PM
4a. Facility Name (If not institution, give street and number): 8113 Daleford Road
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216105608
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 88 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/6/10
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8113 Daleford Road
10f. Zip Code: 21234
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: Hardware

17. Father's Name (First, Middle, Last): Attilio Yenni
18. Mother's Name (First, Middle, Maiden Surname): Christina Varella

19a. Informant's Name/Relationship (Type, Print): Elizabeth Yenni/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 816 Mockingbird Lane, Towson, Maryland 21286

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ALZHEIMER'S DEMENTIA
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Carcinoma bladder

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Barry Joseph MD
29c. License number: D26637
29d. Date signed (Month, Day, Year): 2/19/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BARRY JOSEPH MD 7600 OSLER DR TOWSON MD 21204

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 24 1999
32. Registrar's Signature: P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06174

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GRACE Zimmerman
2. Date of Death: Month Feb Day 21 Year 1999
3. Time of Death: 1370 P.M.
4a. Facility Name (If not institution, give street and number): mercy hospital 301 St Paul Balto MD 21202
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-05-1228
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 9, 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 600 Light Street
10f. Zip Code: 21230
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown — College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): Joseph Thomas Swann
18. Mother's Name (First, Middle, Maiden Surname): Mary Wilhelmina Hutchins

19a. Informant's Name/Relationship (Type, Print): Jim Zimmerman/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1111 Benjamin Road, Bel Air, Maryland 21014

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) — Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. metabolic Acidosis — Approximate Interval Between Onset and Death: minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Lymphoma — months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: 052113
29d. Date signed (Month, Day, Year): Feb 21 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Paul Stromberg 103 E Mt Royal Ave Balto 21202 MD

State Registrar

31. Date filed (Month, Day, Year): MAR 01 1999
32. Registrar's Signature: Regina G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25
30

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06175

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stanley C. Bunnell
2. Date of Death (Month, Day, Year): Feb 18, 1999
3. Time of Death: 5:10 am
4a. Facility Name (If not institution, give street and number): Cumberland Nursing Home
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 040-10-0131
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months, Days — If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Apr 17, 1918
9. Birthplace (State or Foreign Country): CN

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 15 N. Lee Street
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Quality Control Eng.
16b. Kind of Business/Industry: ABL Corp.

17. Father's Name (First, Middle, Last): Charles Bunnell
18. Mother's Name (First, Middle, Maiden Surname): Mary Anna (Valionis)

19a. Informant's Name/Relationship (Type, Print): Catherine Migell--friend
Nellie L. Bunnell-wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 Seymour Street; Cumberland, MD 21502
15 N. Lee Street Cumberland MD 21502

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Mem. Park
Date: 02/20
20c. Location - City or Town, State: Hagerstown MD

21. Signature of Funeral Service Licensee: ▶ Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A.
Cumberland MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. Coronary artery Disease — Approximate Interval Between Onset and Death: 10 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Parkinsonism

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D33280
29d. Date signed (Month, Day, Year): Feb 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Sunil Gupta 625 Kent Avenue Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: ▶

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

MS

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06176

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joshua Kenneth Bullen
2. Date of Death (Month Day Year): Feb. 7, 1999
3. Time of Death: 9:00 PM
4a. Facility Name (If not institution, give street and number): The Heartland House
4b. City, Town, or Location of Death: Grasonville
4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 216-07-6722
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 27, 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Queen Anne's
10c. City, Town or Location: Stevensville
10d. Inside City Limits: 1 [ ] Yes 2 [ ] No
10e. Street and Number: 703 Main Street
10f. Zip Code: 21666
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Captain
16b. Kind of Business/Industry: Ferry System

17. Father's Name (First, Middle, Last): Samuel Chaplain Bullen
18. Mother's Name (First, Middle, Maiden Surname): Bertie G. Sinclair

19a. Informant's Name/Relationship (Type, Print): Sara Bullen - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 703 Main Street, Stevensville, MD 21666

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Memorial Park — Date: Feb.11,1999
20c. Location - City or Town, State: Easton, MD

21. Signature of Funeral Service Licensee: Thomas K. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home P.A. 106 Shamrock Road, Chester, MD 21619

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular ASCVD — Several yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ralph E. Libby
29c. License number: D0005754
29d. Date signed (Month, Day, Year): 2-8-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ralph E. Libby, M.D., 204 Medical Center Road, Grasonville, MD 21638

State Registrar

31. Date filed (Month, Day, Year): FEB 11 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06177

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): YVONNE COATES
2. Date of Death (Month, Day, Year): FEB. 13, 1999
3. Time of Death: 2345
4a. Facility Name (If not institution, give street and number): PRINCE GEORGE'S CTY MEDICAL CENTER
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINE GEORGE'S

Funeral Director

5. Social Security Number: 430-08-6774
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 44 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 31, 1954
9. Birthplace (State or Foreign Country): ARKANSAS

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: WALDORF
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2634 ENTERPRISE PLACE
10f. Zip Code: 20601
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MASTER SGT
16b. Kind of Business/Industry: AIR FORCE

17. Father's Name (First, Middle, Last): ROBERT COATES
18. Mother's Name (First, Middle, Maiden Surname): ARETHA SMITH

19a. Informant's Name/Relationship (Type, Print): SHAVONNE JONES / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2634 ENTERPRISE PLACE WALDORF, MD 20601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LITTLE ROCK NATIONAL CEM. — Date: 2/22/99
20c. Location - City or Town, State: LITTLE ROCK ARKANSAS

21. Signature of Funeral Service Licensee: ▶ Lloyd M. [illegible]
22. Name and Address of Facility: ADAMS FUNERAL HOME, P.A. 20605 AQUASCO ROAD AQUASCO, MD 20608

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. MASSIVE SUBARACHNOID HEMORRHAGE — Approximate Interval Between Onset and Death

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D 43662
29d. Date signed (Month, Day, Year): 2/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Boyce 3001 Hospital DRIVE CHEVERLY MD 20785

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: ▶ [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06178

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VIRGINIA LEE DUNCAN
2. Date of Death (Month, Day, Year): FEBRUARY 17, 1999
3. Time of Death: 1615
4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 212-18-1938
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sep 16, 1920
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cresaptown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 14802 Connecticut Avenue
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Retired co-owner
16b. Kind of Business/Industry: Duncan Cycle Shop
17. Father's Neme *(First, Middle, Last)*: William Kreiger
18. Mother's Name *(First, Middle, Maiden Sumame)*: Cecelia (Davis)
19a. Informant's Name/Relationship *(Type, Print)*: David R. Duncan--son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14802 Connecticut Avenue; Cresaptown, MD 21502
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hillcrest Memorial Park
Date: 02/20
20c. Location - City or Town, State: Cumberland, MD 21502
21. Signature of Funeral Service Licensee: ▶ Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular Fibrillation — minutes

Due to (or as a consequence of):
b. Myocardial Infarct — 1 hr.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*
29a. Certifier *(Check only one)*: 1☒ **Certifying Phyalcian:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Guy Fiscus MD
29c. License number: D12779
29d. Date signed *(Month, Day, Year)*: 2/19/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Guy Fiscus, M.D.; 500 Memorial Avenue; Cumberland, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 19 1999
32. Registrar's Signature: ▶

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

MS

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06179

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William David Duvall
2. Date of Death (Month, Day, Year): Feb. 4, 1999
3. Time of Death: 9:45P.M.
4a. Facility Name (If not institution, give street and number): Memorial Hospital of Easton
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 577-18-9785
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 25, 1913
9. Birthplace (State or Foreign Country): Wash., D.C.

Usual Residence of Decedent

10a. State: Md.
10b. County: Queen Anne's
10c. City, Town or Location: Centreville
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 108 Windsor Avenue
10f. Zip Code: 21617
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Budget Analyst
16b. Kind of Business/Industry: Federal Govt.
17. Father's Name (First, Middle, Last): Charles R. Duvall
18. Mother's Name (First, Middle, Maiden Surname): Carrie Opie
19a. Informant's Name/Relationship (Type, Print): W. David Duvall, Jr. (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 Windsor Ave., Centreville, Md. 21617
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesterfield Cemetery — Date: Feb. 9, 1999
20c. Location - City or Town, State: Centreville, Md.
21. Signature of Funeral Service Licensee: Amy L. Michaels
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, 408 S. Liberty St., Centreville, Md.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. sepsis — week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. dementia — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kathleen Hoey
29c. License number: D47627
29d. Date signed (Month, Day, Year): Feb. 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kathleen Hoey, M.D.; 2540 Centreville Rd.; Centreville, Md. 21617

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 08 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06180

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rosalie Connolly Duvall
2. Date of Death (Month, Day, Year): February 7,1999
3. Time of Death: 10:31AM
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 212-14-4722
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 14,1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Queen Anne's
10c. City, Town or Location: Centreville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 108 Windsor Avenue
10f. Zip Code: 21617
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Self
17. Father's Name (First, Middle, Last): Edward James Connolly
18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Boyle
19a. Informant's Name/Relationship (Type, Print): W. David Duvall,Jr. Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 Windsor Ave.,Centreville, Md. 21617
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesterfield Cemetery | Date: Feb. 9,1999
20c. Location - City or Town, State: Centreville, Md.
21. Signature of Funeral Service Licensee: Thomas K. Helfenbein
22. Name and Address of Facility: Fellows,Helfenbein & Newnam Funeral Home 408 S. Liberty St., Centreville, Md.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. RESPIRATORY ARREST	5min
Due to (or as a consequence of):	b. B/L PNEUMONIAS	4D
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. PROFOUND METABOLIC ACIDOSIS	2D
	Due to (or as a consequence of): d. RENAL FAILURE	2D
	e. RECURRENT GI BLEEDING	4D

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ESOPHAGEAL VARICIES
PORTAL HYPERTENSION
STEATOHEPATITIS
DIABETES
HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John R. Condit
29c. License number: H41416
29d. Date signed (Month, Day, Year): 2/7/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John R. Condit,M.D.; 403 Marvel Ct., Easton, Md. 21601

State Registrar

31. Date filed (Month, Day, Year): FEB 08 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Duvall,Rosalie
Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06181

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JEANNETTE GROSS
2. Date of Death (Month Day Year): February 15, 1999
3. Time of Death: 1:29 A.M.
4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL & MEDICAL CENTER
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 219-14-5035
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT 26 1915
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 408 NORTH MECHANIC STREET
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12+ College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OWNER/OPERATOR HARDWARE STORE
16b. Kind of Business/Industry: HEATING & HARDWARE/PLUMBING
17. Father's Name (First, Middle, Last): SOLOMON GROSS
18. Mother's Name (First, Middle, Maiden Surname): LEOTA HIMMLER
19a. Informant's Name/Relationship (Type, Print): ROBERT A. GROSS BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 408 NORTH MECHANIC STREET CUMBERLAND MARYLAND 21502
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HILLCREST CEMETERY
Date: FEB 17 1999
20c. Location - City or Town, State: CUMBERLAND MARYLAND
21. Signature of Funeral Service Licensee: Dale L. Merritt
22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. ACUTE RENAL FAILURE	72 HOURS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. CORONARY ARTERY DISEASE	10 YEARS
Due to (or as a consequence of):		
	c. SMALL CELL CARCINOMA LUNG	3 WEEKS
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Zaman
29c. License number: D 23371
29d. Date signed (Month, Day, Year): February 15 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Qamar Zaman, Johnson Heights Medical Building 625 Kent Avenue Suite 102 Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature:

JEANETTE GROSS 219-14-5035

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06182

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Linda Lee Glidden
2. Date of Death: Month Feb. Day 6 Year 1999
3. Time of Death: 12:23 PM
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-42-1102
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 53 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 5, 1945
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Queen Anne's
10c. City, Town or Location: Grasonville
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 107 Main Court
10f. Zip Code: 21638
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Deli Manager
16b. Kind of Business/Industry: Retail
17. Father's Name (First, Middle, Last): Carroll E. Whittington
18. Mother's Name (First, Middle, Maiden Surname): Elsie May Schultz
19a. Informant's Name/Relationship (Type, Print): Brandee Diggs - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6901 Rabbit Run Road, Hurlock, MD 21643
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Cremation Center LLC. Date: Feb. 10, 1999
20c. Location - City or Town, State: Stevensville, MD
21. Signature of Funeral Service Licensee: Amy L. Michaels
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Posterior fossa Hemorrhage

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Physician
29c. License number: D47518
29d. Date signed (Month, Day, Year): 2/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theresa Bruk AAMC Franklin Cathedral St Annapolis MD 21401

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 08 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06183

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert M. Neal
2. Date of Death: Month 02 Day 15 Year 99
3. Time of Death: 10^05 am
4a. Facility Name (If not institution, give street and number): University of Maryland Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-14-5840
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02-May-23
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Frostburg
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 161 Bowery Steet
10f. Zip Code: 21532-
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Restaurant
17. Father's Name (First, Middle, Last): James Enoch Neal
18. Mother's Name (First, Middle, Maiden Surname): Mary Cook
19a. Informant's Name/Relationship (Type, Print): Mary V. Neal Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 Southfield Place Baltimore Maryland 21212-
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Frostburg Memorial Park
Date: 21-Feb-99
20c. Location - City or Town, State: Frostburg, Maryland
21. Signature of Funeral Service Licensee: ▶ John R. Durst
22. Name and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	24 hours
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Left hip infection	WKS
Due to (or as a consequence of):		
	c. Necrotizing fascitis	YRS
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: 381234
29d. Date signed (Month, Day, Year): 10^05 am on 2/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Garrettson Ellis 22 South Greene St N3E07

21

MS

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: ▶ [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

219-14-5840 75 02-May-23 Maryland

Maryland Allegany Frostburg

161 Bowery Street

21532- U.S.A.

White

12 0 Manager Restaurant

James Enoch Neal Mary Cook

Mary V. Neal Sister 17 Southfield Place Baltimore Maryland 21212-

Frostburg Memorial Park 21-Feb-99 Frostburg, Maryland

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06184

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GERTRUDE TERESA NOTTINGHAM
2. Date of Death: Month Febuary Day 16 Year 1999
3. Time of Death: 9:10pm
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 577-26-4210
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 78 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 29, 1920
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: Cobb Island
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 12116 Neale Sound Drive
10f. Zip Code: 20625
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Patrick Joseph Gough
18. Mother's Name (First, Middle, Maiden Surname): Rose Harrity Gough

19a. Informant's Name/Relationship (Type, Print): Cecilia Logan/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17423 Pipers Way Olney, MD 20832

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans
Date: 2/19/99
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: David C. Echols M00945
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME P.A. P.O. BOX 567 LA PLATA, MD 20646

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Edema
Due to (or as a consequence of):
b. Left Malignant pleural effusion
Due to (or as a consequence of):
c. Lung Cancer
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Date of Injury (Month, Day, Year)
28c. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Songchol Chon M.D.
29c. License number: D - 37174
29d. Date signed (Month, Day, Year): 2/16/1999
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Song C. Chon, MD 7C Post Office Road, Waldorf, Maryland 20602

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

Gertrude Nottingham

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

99-0924-033
crn
Michael Parks

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #2,3, PER MEO G769 3-9-99 WR.
ITEMS: #23 PART I, 27 PER MEO G769 3-2-99 WR.

Certificate of Death

Reg. No. 99 06185

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael J. Parks
2. Date of Death: Month February, Day 17 ~~16~~, Year 1999
3. Time of Death: 7:15 ~~7:14~~ P.M.
4a. Facility Name (If not institution, give street and number): Malcolm Growe Hospital
4b. City, Town, or Location of Death: Camp Springs
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-74-1344
6. Sex: [X] M [ ] F
7. Age (In yrs. last birthday): 45 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 11, 1953
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Temple Hills
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3919 23rd Pkwy. #32
10f. Zip Code: 20748
10g. Citizen of What Country? U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mail Handler
16b. Kind of Business/Industry: United States Postal Service
17. Father's Name (First, Middle, Last): Hoge Alfred Parks
18. Mother's Name (First, Middle, Maiden Surname): Margaret Davidson
19a. Informant's Name/Relationship (Type, Print): Ms. Debra Walker (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3004 Metronome Turn CLinton, Maryland 20735
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): National Harmony Memorial Park — Date: 2/24/99
20c. Location - City or Town, State: Landover, Maryland
21. Signature of Funeral Service Licensee: Janet C. Anderson
22. Name and Address of Facility: Rollins Funeral Home, Inc. 4339 Hunt Place,N.E. Washington, D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. HYPERTROPHIC CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Jean Lake MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): February 19, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 26 1999
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06186

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ada Eleanor Ritchie
2. Date of Death: Month February Day 17 Year 1999
3. Time of Death: 03:40 AM
4a. Facility Name (If not institution, give street and number): Saint Vincent de Paul Nursing Care Cent
4b. City, Town, or Location of Death: Frostburg
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 215-16-4594
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 77 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 16-Dec-21
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Frostburg
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 19703 Woodland Road
10f. Zip Code: 21532-
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: Income Tax Services
17. Father's Name (First, Middle, Last): Theodore R. Buckingham
18. Mother's Name (First, Middle, Maiden Surname): Martha Yantz
19a. Informant's Name/Relationship (Type, Print): Doris Troutman Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 176 West Main Street Frostburg Maryland 21532-
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Frostburg Memorial Park
Date: 19-Feb-99
20c. Location - City or Town, State: Frostburg, Maryland
21. Signature of Funeral Service Licensee: John R. Durst
22. Name and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION — Approximate Interval Between Onset and Death: 30 MINUTES
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CONGESTIVE Heart Failure
CORONARY Artery DISEASE
Old Cerebral Infarct

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: S Chang MD
29c. License number: D25638
29d. Date signed (Month, Day, Year): February 18, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. T. Chang, M.D., Frostburg Plaza, Frostburg, Maryland 21532

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Ada Eleanor Ritchie

Saint Vincent de Paul Nursing Care Cent Frostburg Allegany

215-16-4594 77 16-Dec-21 Maryland

Maryland Allegany Frostburg

19703 Woodland Road

21532- U.S.A.

White

12 0 Bookkeeper Income Tax Services

Theodore R. Buckingham Martha Yantz

Doris Troutman Daughter 176 West Main Street Frostburg Maryland 21532-

Frostburg Memorial Park 19-Feb-99 Frostburg, Maryland

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

S. I. Chang, M.D., Frostburg Plaza, Frostburg, Maryland 21532

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06187

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rena E. Ringgold
2. Date of Death (Month, Day, Year): February 5, 1999
3. Time of Death: 1:20 AM
4a. Facility Name (If not institution, give street and number): Future Care - Cherrywood
4b. City, Town, or Location of Death: Reisterstown
4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 219-18-4451
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 29, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Queen Anne's
10c. City, Town or Location: Chester
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 229 Dominion Road
10f. Zip Code: 21619
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales
16b. Kind of Business/Industry: Telemarketing

17. Father's Name (First, Middle, Last): John A. Walters
18. Mother's Name (First, Middle, Maiden Surname): Lillian Twigg

19a. Informant's Name/Relationship (Type, Print): Cindy Ringgold-Goble, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 647 Johahn Drive, Westminster, MD 21158

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Stevensville Cemetery
Date:
20c. Location - City or Town, State: Stevensville, MD

21. Signature of Funeral Service Licensee: ▶ Amy Jo Michiewicz
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Dilated cardiomyopathy — Approximate Interval Between Onset and Death: YRS
Due to (or as a consequence of):
b. Coronary Artery Disease — YRS
Due to (or as a consequence of):
c. Atherosclerotic cardiovascular disease — YRS
Due to (or as a consequence of):
d. Chronic lung Disease — YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
peripheral vascular disease
Sternal osteomyelitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Kenneth K. Zonies MD
29c. License number: D 28333
29d. Date signed (Month, Day, Year): 2/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1838 Greentree Rd Pikesville MD K. Zonies MD

State Registrar

31. Date filed (Month, Day, Year): FEB 08 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Amended # 23(b), MDS, 2/18/99, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06188

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT Shewbridge
2. Date of Death (Month, Day, Year): February 9, 1999
3. Time of Death: 11:54 PM
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-40-3276
6. Sex: X M 2 F
7. Age (In yrs. last birthday): 55 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 7, 1943
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: X Yes 2 No
10e. Street and Number: 13701 Uhl Highway
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married X Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes X No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Purchasing Manager
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Ersal Shewbridge
18. Mother's Name (First, Middle, Maiden Surname): Virginia (Andrews)

19a. Informant's Name/Relationship (Type, Print): Brenda Shewbridge--wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13701 Uhl Highway; Cumberland, MD 21502

20a. Method of Disposition: X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hillcrest Memorial Park
Date: 02/13
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardiopulmonary arrest — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Coronary artery disease — 2 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: acute renal failure, metabolic acidosis

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA — Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ward J, MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): February 10 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marcelo Ovejado 600 North Wolfe Street Baltimore, MD 21287-9106

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

15

Rev D. Barbour MDS

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06189

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Gitt Thompson
2. Date of Death (Month, Day, Year): Feb.7,1999
3. Time of Death: 11:50AM
4e. Facility Name (If not institution, give street and number): 402 Chesterfield Ave.
4b. City, Town, or Location of Death: Centreville
4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 218-07-1832
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr.29,1918
9. Birthplace (State or Foreign Country): West Va.

Usual Residence of Decedent

10a. State: Md.
10b. County: Queen Anne's
10c. City, Town or Location: Centreville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 402 Chesterfield Ave.
10f. Zip Code: 21617
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Self

17. Father's Name (First, Middle, Last): Earl M. Gitt
18. Mother's Name (First, Middle, Maiden Surname): Daisy Clark

19a. Informant's Name/Relationship (Type, Print): Husband William E. Thompson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 402 Chesterfield Ave., Centreville, Md. 21617

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Cremation Center — Date: Feb.9, 1999
20c. Location - City or Town, State: Stevensville, Md.

21. Signature of Funeral Service Licensee: Thomas K. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, 408 S. Liberty St., Centreville, Md.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. aortic aneurysm — Approximate Interval Between Onset and Death: years
Due to (or as a consequence of):
b. coronary artery disease — years
Due to (or as a consequence of):
c. hypertension — years
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
enterocolitis
hypercholesterolemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Kathleen Hoey
29c. License number: D47627
29d. Date signed (Month, Day, Year): Feb. 8, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kathleen Hoey, M.D.; 2540 Centreville Rd.,;Centreville, Md. 21617

State Registrar

31. Date filed (Month, Day, Year): FEB 11 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06190

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Veasel
2. Date of Death (Month, Day, Year): Feb. 7, 1999
3. Time of Death: 5:30 AM
4a. Facility Name (If not institution, give street and number): 12 Oregon Road
4b. City, Town, or Location of Death: Stevensville
4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 216-12-5051
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months, Days — If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): March 14, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Queen Anne's
10c. City, Town or Location: Stevensville
10d. Inside City Limits: 1 [ ] Yes 2 [ ] No
10e. Street and Number: 12 Oregon Road
10f. Zip Code: 21666
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII.
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self-Employed
16b. Kind of Business/Industry: Ceramics

17. Father's Name (First, Middle, Last): George Zachias Veasel
18. Mother's Name (First, Middle, Maiden Surname): Mary L. Downes

19a. Informant's Name/Relationship (Type, Print): Audrey L. Veasel
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Oregon Road, Stevensville, MD 21666

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crestlawn Memorial Garden — Date: Feb. 10, 1999
20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: Amy L. McCleary
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE MYELOMA — Approximate Interval Between Onset and Death: 2 1/2 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Stanley P. Watkins
29c. License number: D06118
29d. Date signed (Month, Day, Year): 2/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stanley P. Watkins, Jr., M.D., 900 Bestgate Road, Suite 300, Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year): FEB 08 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06191

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Spencer Watkins
2. Date of Death (Month, Day, Year): Feb. 7, 1999
3. Time of Death: 10:10AM
4a. Facility Name (If not institution, give street and number): Chestertown Nursing & Rehab. Center
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 218-18-2721
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Jan. 1, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Queen Anne's
10c. City, Town or Location: Centreville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 605 Rowe-Ingleside Rd.
10f. Zip Code: 21617
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter
16b. Kind of Business/Industry: U.S. Naval Academy

17. Father's Name (First, Middle, Last): William Watkins
18. Mother's Name (First, Middle, Maiden Surname): Lillie May Nichels

19a. Informant's Name/Relationship (Type, Print): Katherine Watkins-Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 605 Rowe-Ingleside Rd., Centreville, Md. 21617

20a. Method of Disposition: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Church Hill Cemetery
Date: Feb. 11, 1999
20c. Location - City or Town, State: Church Hill, Md.

21. Signature of Funeral Service Licensee: Thomas K. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, 408 S. Liberty St., Centreville, Md.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory arrest	1-2 min.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. COPD exacerbation	1 month
	Due to (or as a consequence of):	
	c. Hypoxia	6 hrs
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes
Pneumonia

23b. Did tobacco use contribute to the cause of death? [X] 1 Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: [X] 4 Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): [X] 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D51735
29d. Date signed (Month, Day, Year): 2/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frederick Delboy, M.D.; 6602 Church Hill Rd.; Chestertown, Md. 21620

State Registrar

31. Date filed (Month, Day, Year): FEB 08 1999
32. Registrar's Signature: Geneva G. Sparks

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 19a per F.H G-769 3/8/99 reb

Certificate of Death

Reg. No. 99 06192

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald D. Anderson SR.
2. Date of Death: Month February Day 25 Year 1999
3. Time of Death: 3:30 AM
4a. Facility Name (If not institution, give street and number): Liberty Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 211-16-9726
6. Sex: [X] M [ ] F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02 04 30
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3831 Cottage Ave
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th grade
College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foam Laborer
16b. Kind of Business/Industry: HLS Foam Rubber Fabric Company

17. Father's Name (First, Middle, Last): John Wesley Anderson
18. Mother's Name (First, Middle, Maiden Surname): Maggie Miller

19a. Informant's Name/Relationship (Type, Print): John ~~Johnson~~ Jackson Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3831 Cottage Ave, Baltimore md 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery
Date: 3/3/99
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: ▶ James J. Flowers
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Anoxic Encephalopathy	3 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Myocardial Infarction	3 days
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Laryngeal Cancer

23b. Did tobacco use contribute to the cause of death? 1 [✓] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ George E. Wicks III M.D.
29c. License number: D41365
29d. Date signed (Month, Day, Year): February 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George E. Wicks III M.D. 2600 Liberty Heights Ave 21215

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: ▶ Donna G. Sparks

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DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 06193

Item:19a per F.H G-769 3/16/99 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROGELIO BALLESTEROS ALBUERO
2. Date of Death (Month Day Year): FEBRUARY 17, 1999
3. Time of Death: 21:10
4a. Facility Name (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER
4b. City, Town, or Location of Death: ANNAPOLIS
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 214-82-8147
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 24, 1936
9. Birthplace (State or Foreign Country): PHILIPPINES

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: PRINCE GEORGE
10c. City, Town or Location: LANDOVER
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 7206 KENT TOWN DRIVE
10f. Zip Code: 20785
10g. Citizen of What Country?: PHILIPPINES

To Be Completed by Funeral Director

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: PHILIPPINO
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ACCOUNTANT
16b. Kind of Business/Industry: LAW FIRM
17. Father's Name (First, Middle, Last): FRANCISCO ALBUERO
18. Mother's Name (First, Middle, Maiden Surname): JUANITA BALLESTEROS
19a. Informant's Name/Relationship (Type, Print): ROSALINA M. ~~ALBUERO~~ Albuero/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7206 KENT TOWN DRIVE, LANDOVER, MARYLAND 20785
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE WASHINGTON CREMATORY | Date: 2/25/99
20c. Location - City or Town, State: LAUREL, MARYLAND
21. Signature of Funeral Service Licensee: Janice A Fleck
22. Name and Address of Facility: FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Possible myocardial infarction
Due to (or as a consequence of):
b. Diabetes Mellitus Type II
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism

Hypercholesterolemia

Heavy Smoker, COPD

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Amelia C. Villaruz
29c. License number: D26317
29d. Date signed (Month, Day, Year): 2/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Amelia C. Villaruz, M.D., Crownsville Hospital Center, 1520 Crownsville Road Crownsville, MD 21032

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06194

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Elizabeth Burns
2. Date of Death (Month, Day, Year): FEBRUARY, 27, 1999
3. Time of Death: 16:45pm
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 218-18-3468
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8-15-1925
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5511 Lothian Road
10f. Zip Code: 21212
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade — College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Environmental Service
16b. Kind of Business/Industry: Baltimore Public Schools
17. Father's Name (First, Middle, Last): Freeman Gray
18. Mother's Name (First, Middle, Maiden Surname): Florence Johnson
19a. Informant's Name/Relationship (Type, Print): George Burns - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1370 Eagle Avenue Norfolk, Va 23518
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park — Date: 3-4-99
20c. Location - City or Town, State: Arbutus, Md
21. Signature of Funeral Service Licensee: Lynette K. Jones
22. Name and Address of Facility: March F.H. West, 4300 Wabash Avenue Baltimore, Md 21215

Physician /Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASPIRATION PNEUMONIA	24 HRS
Due to (or as a consequence of):	b. BRAINSTEM CEREBROVASCULAR ACCIDENT	24 HRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD
29c. License number: P12333
29d. Date signed (Month, Day, Year): FEBRUARY, 27, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JOSEPHINE OWUSU-SAKYI, 2401 BELVEDERE AVE, BALTIMORE, MD 21215

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

MILDRED BURNS
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD
99-1114-510

VIRGINIA
BASKERVILLE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06195

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Virginia Lee Baskerville
2. Date of Death (Month, Day, Year): FEBRUARY 25, 1999
3. Time of Death: 6:12P.M.
4a. Facility Name *(If not institution, give street and number)*: HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-18-5826
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 15, 1924
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 635 Hillview Rd.
10f. Zip Code: 21225
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* African American

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: John Powell
18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah Powell
19a. Informant's Name/Relationship *(Type, Print)*: Ms. June Baskerville (daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 635 Hillview Rd. Balto. Md. 21225
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest — Date: 3/4/99
20c. Location - City or Town, State: Owings Mills, Md.
21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home, 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? INSPECTION 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Margarita Korell
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: FEBRUARY 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 - 1999
32. Registrar's Signature: B. Sparks

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DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06196

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RALPH BEASLEY
2. Date of Death: Month 02 Day 24 Year 99
3. Time of Death: 3:40PM
4a. Facility Name (If not institution, give street and number): BALTIMORE VA MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 247-28-8855
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 77 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03/11/1921
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10e. State: SC
10b. County: DARLINGTON
10c. City, Town or Location: DARLINGTON
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1233 STILLFORK ROAD
10f. Zip Code: 29532
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MILL WORKER
16b. Kind of Business/Industry: LUMBER INDUSTRY
17. Father's Name (First, Middle, Last): ROLAND BEASLEY
18. Mother's Name (First, Middle, Maiden Surname): HATTIE HOOKS
19a. Informant's Name/Relationship (Type, Print): ELSIE BROWN/
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 831 REVERDY ROAD BALTIMORE, MD 21212
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): U.S. VETERANS CEMETERY
Date: 03/01/99
20c. Location - City or Town, State: FLORENCE, SC
21. Signature of Funeral Service Licensee: ▶ Robert C. Sterling
22. Name and Address of Facility: STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASPIRATION	4 DAYS
Due to (or as a consequence of):	b. ANOXIC BRAIN INJURY	4 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: P-11195
29d. Date signed (Month, Day, Year): 2/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL PALESE, MD BALTIMORE VA MEDICAL CENTER

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06197

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BENJAMIN BROWN
2. Date of Death: Month February Day 26 Year 1999
3. Time of Death: 3:30 p.m.
4a. Facility Name (If not institution, give street and number): UNIVERSITY of MARYLAND MEDICAL SYSTEM
4b. City, Town, or Location of Death:
4c. County of Death: NA

Funeral Director

5. Social Security Number: 434-31-8119
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 35 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 04-15-63
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2710 Guilford Avenue
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: various trades
17. Father's Name (First, Middle, Last): Benjamin Brown, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Edith Doane
19a. Informant's Name/Relationship (Type, Print): Edith Brown
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2710 Guilford Avenue Baltimore, Maryland 21218
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Pk. Cem. Date: 03-03-99
20c. Location - City or Town, State: Randallstown, MD
21. Signature of Funeral Service Licensee: Bernard D Johnson
22. Name and Address of Facility: WM.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. pneumothorax — Approximate Interval Between Onset and Death: 5 days
Due to (or as a consequence of):
b. previous bilat Pneumocystis disease — unknown
Due to (or as a consequence of):
c. AIDS
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J Nazarian MD Resident physician
29c. License number: R8485
29d. Date signed (Month, Day, Year): February 26, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. NAZARIAN M.D. 22 S. Greene St. Baltimore, Md 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06198

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carrie L. Blocker
2. Date of Death: Month Feb. Day 26, Year 99
3. Time of Death: 0030am
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 216-26-7907
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-26-35
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1617 Northwick Road
10f. Zip Code: 21218
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade — College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postal worker
16b. Kind of Business/Industry: Post Office
17. Father's Name (First, Middle, Last): Andrew Thorne
18. Mother's Name (First, Middle, Maiden Surname): Alice Boyd
19a. Informant's Name/Relationship (Type, Print): Darlene Price
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1617 Northwick Road Baltimore, Maryland 21218
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery — Date: 03-03-99
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Bernard D Johnson
22. Name and Address of Facility: WM.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. metastatic Breast cancer — 1 year
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D44944
29d. Date signed (Month, Day, Year): March 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stanley Walker 3333 North Calvert Street Baltimore Md 21218

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Received B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06199

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret E. Butler
2. Date of Death: Month March Day 01 Year 1999
3. Time of Death: 9:30AM
4a. Facility Name (If not institution, give street and number): 2511 Christian Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-24-8594
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 25, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2511 Christian Street
10f. Zip Code: 21223
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Anthony Spurrier
18. Mother's Name (First, Middle, Maiden Surname): Katherine Kramer
19a. Informant's Name/Relationship (Type, Print): Ralph D. Butler (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4928 Ocean Pines Berlin, Maryland 21811
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 3/03/1999
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Renal Failure — 5 Years

Due to (or as a consequence of):

b. Hypertension — 3 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D40012
29d. Date signed (Month, Day, Year): March 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott C. Poulton, M.D. 4600 Wilkens Avenue Baltimore, Maryland 21229

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06200

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Willis Guy Bolyard
2. Date of Death: Month March, Day 02, Year 1999
3. Time of Death: 4:15AM
4a. Facility Name (If not institution, give street and number): 1204 Sargeant Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 723-09-0970
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 9, 1923
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1204 Sargeant Street
10f. Zip Code: 21223
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cement Mason
16b. Kind of Business/Industry: Construction
17. Father's Name (First, Middle, Last): Josaih Bolyard
18. Mother's Name (First, Middle, Maiden Surname): Nora Nice
19a. Informant's Name/Relationship (Type, Print): Nathalie Bolyard
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1204 Sargeant Street Baltimore, Maryland 21223
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ ~~Removal from State~~ 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. View Church Cemetery
Date: 3/5/99
20c. Location - City or Town, State: Tunnelton, West Virginia
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ambrose Funeral Home of Lansdowne, 2719 Hammonds Ferry Road Lansdowne, MD 21227

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Parkinson's disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Emphysema, esophagitis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 20040
29d. Date signed (Month, Day, Year): 3/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Evans MD, 700 Washington Blvd, Balto, Md 21230

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item#20b perFH G769 3/2/99 EW

Certificate of Death

Reg. No. 99 06201

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IRA BROWN
2. Date of Death (Month, Day, Year): FEBRUARY 27, 1999
3. Time of Death: 9:50 PM
4a. Facility Name (If not institution, give street and number): NORTH OAKS HEALTH CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 110-16-8087
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR. 5, 1908
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yes [X] No
10e. Street and Number: 725 MT. WILSON LANE
10f. Zip Code: 21208
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OWNER
16b. Kind of Business/Industry: HARDWARE STORE
17. Father's Name (First, Middle, Last): JOSEPH BROWN
18. Mother's Name (First, Middle, Maiden Surname): ROSE (UNKNOWN)
19a. Informant's Name/Relationship (Type, Print): RALPH BROWN / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12306 HAPPY HOLLOW ROAD - COCKEYSVILLE, MD 21030
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. HOPE CEMETERY
Date: 3/~~4~~2/99
20c. Location - City or Town, State: ROCHESTER, NY
21. Signature of Funeral Service Licensee: Robert Brown
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

IRA BROWN

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia

Atrial Fibrillation.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christopher Tsh
29c. License number: D53283
29d. Date signed (Month, Day, Year): 2/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher Tsh 1147 South Hanover St Baltimore MD 21230

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 06202

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHIRLEY L. BELAGA
2. Date of Death (Month, Day, Year): FEBRUARY 24, 1999
3. Time of Death: 4:20 PM
4a. Facility Name (If not institution, give street and number): 6701 PARK HEIGHTS AVENUE #1B
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-03-6906
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 15, 1919
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 6711 PARK HEIGHTS AVENUE #118
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY
16b. Kind of Business/Industry: ASSOC. JEWISH CHARITY
17. Father's Name (First, Middle, Last): FRANK BRILL
18. Mother's Name (First, Middle, Maiden Surname): MARY ACKERMAN
19a. Informant's Name/Relationship (Type, Print): GAIL HORWITZ / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6701 PARK HEIGHTS AVE. #1B - BALTIMORE, MD 21215
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WORKMEN CIRCLE CEMETERY — Date: 2/26/99
20c. Location - City or Town, State: BALTIMORE, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Coronary artery disease — 15 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) DAUGHTER RESIDENCE

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D18095
29d. Date signed (Month, Day, Year): 2-25-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael T Rudnitoff 222 W. Cold Spring Lane Balto MD 21210

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06203

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Johnny Bowles
2. Date of Death (Month, Day, Year): February 24, 1999
3. Time of Death: 8:56 AM
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 225-52-1082
6. Sex: 1☐ M 2☐ F XX
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 15, 1943
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: VA
10b. County:
10c. City, Town or Location: Richmond
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3200 Cliff Avenue
10f. Zip Code: 23232
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2☐ No If Yes, Give Year or Dates: 1965 to 1969
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Reporter
16b. Kind of Business/Industry: Newpaper
17. Father's Name (First, Middle, Last): Johnny A. Bowles, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Lula Washington
19a. Informant's Name/Relationship (Type, Print): William F. Bowles - Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3907 Noyes Circle #4 Randallstown, MD 21133
20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Cemetery | Date: 2/28/99
20c. Location - City or Town, State: Charlottesville, VA
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bell Funeral Home, 108 6th Street NW Charlottesville, VA22903

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Myocardial Infarction	15 Min.
	Due to (or as a consequence of): Volume Depletion	1 Hour
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Enferitis	2 Days
	c. Due to (or as a consequence of): End Stage Emphysema	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No XX Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes XX No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes XX No

25. Was case referred to medical examiner? XX Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: XX Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D38956
29d. Date signed (Month, Day, Year): Febry 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward Allen Seidel MD, 5601 Loch Raven Blvd, Baltimore, MD 21239-2995.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06204

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rita Beck
2. Date of Death: Month Feb Day 25 Year 1999
3. Time of Death: 18:20
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 233-36-9180
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/7/1924
9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MD
10b. County: HOWARD
10c. City, Town or Location: SYKESVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13388 PIPES LANE
10f. Zip Code: 21784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BOOKKEEPER
16b. Kind of Business/Industry: SOCIAL SECURITY ADMINISTRATION

17. Father's Name (First, Middle, Last): ADRIAN ALEXANDER BOSWELL
18. Mother's Name (First, Middle, Maiden Surname): ADA (THOMASSON)

19a. Informant's Name/Relationship (Type, Print): WILBUR BECK (HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13388 PIPES LANE SYKESVILLE, MD 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CRESTLAWN MEMORIAL PARK
Date: 3/2/99
20c. Location - City or Town, State: MARRIOTTSVILLE, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE CATONSVILLE, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Anoxia
Due to (or as a consequence of):
b. Pneumothorax
Due to (or as a consequence of):
c. end stage lung cancer.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D50973
29d. Date signed (Month, Day, Year): Feb 26, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACOB CHERIAN Patuxent Medical Group Twoknoll North DR. Columbia Md 21045

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06205

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Ann Braczynski
2. Date of Death (Month, Day, Year): February 28, 1999
3. Time of Death: 12:22PM
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 086-32-5471
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 58 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 23, 1940
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Sparks
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 23 Rainflower Path Unit 304
10f. Zip Code: 21152
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Operator
16b. Kind of Business/Industry: Medical
17. Father's Name (First, Middle, Last): John George Gabrys
18. Mother's Name (First, Middle, Maiden Surname): Bertha Rose Hosinska
19a. Informant's Name/Relationship (Type, Print): W. Douglas Braczynski/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3641 Fox Meadow Ct. Jarrettsville, MD 21084
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Washington Crematory
Date: March 01,1999
20c. Location - City or Town, State: Laurel, MD
21. Signature of Funeral Service Licensee: Michael J. Flagle
22. Name and Address of Facility: Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road Timonium, MD 21093

To Be Completed by Funeral Director

Fe bruary 28, 1999 12:22 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Myeloma
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 15504
29d. Date signed (Month, Day, Year): 2-28-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Eddie Nakhuda, 2300 Dulaney Valley Rd., Timonium, MD 21093

Medical Certification: To Be Completed by Physician/Medical Examiner

Maryann Braczynski

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06206

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KATHERINE STROHECKER BUTZ
2. Date of Death (Month, Day, Year): February 26, 1999
3. Time of Death: 2:20 A.M.
4a. Facility Name (If not institution, give street and number): Roland Park Place
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-01-9284
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 16, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 830 W. 40th Street
10f. Zip Code: 21211
10g. Citizen of What Country?: USA
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 12th
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assistant to the President
16b. Kind of Business/Industry: Shipping
17. Father's Name (First, Middle, Last): Joseph Jacob Strohecker
18. Mother's Name (First, Middle, Maiden Surname): Katherine Coskery
19a. Informant's Name/Relationship (Type, Print): George Strohecker (Nephew)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 802 Regester Avenue, Baltimore, Maryland 21239
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery
Date: 3/2/99
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Martin D. Lawson
22. Name and Address of Facility: Mitchell-Wiedefeld Home, 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): e. Renal Shunt Thrombosis
Due to (or as a consequence of):
b. Chronic Renal Failure
Due to (or as a consequence of):
c. C.O.P.D., Advanced
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: E. Hunter Wilson
29c. License number: D12487
29d. Date signed (Month, Day, Year): 3-1-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): E. Hunter Wilson, M.D., 6701 North Charles Street, Baltimore, Maryland 21204

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: Irene B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

218 05 0735

Reg. No: 99 06207

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNABELLE MADELINE BICKEL
2. Date of Death — Month: FEBRUARY Day: 26 Year: 1999
3. Time of Death: 12-15 AM
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-05-0735
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR 6, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2920 Sylvan Avenue
10f. Zip Code: 21214
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): UNK.
18. Mother's Name (First, Middle, Maiden Surname): Margaret Gavaghan

19a. Informant's Name/Relationship (Type, Print): Kaaren S. Goetz/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2920 Sylvan Avenue Baltimore, MD 21214

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. — Date: 2/26/99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. END STAGE PARKINSON'S DISEASE — 2 MONTH

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MEDICAL DOCTOR
29c. License number: D 0052277
29d. Date signed (Month, Day, Year): FEBRUARY 26TH 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): FRANCIS KWASHIE ATTOGBE GOOD SAMARITAN HOSPITAL OF MARYLAND INC.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06208

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian May Brooks
2. Date of Death (Month, Day, Year): February 25, 1999
3. Time of Death: 12:40 AM
4a. Facility Name (If not institution, give street and number): Homestead Manor
4b. City, Town, or Location of Death: Denton
4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 219-36-7351
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Sept. 26, 1905
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Denton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 410 Colonial Drive
10f. Zip Code: 21629
10g. Citizen of What Country?: U.S.A.

To Be Completed by Funeral Director

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: School
17. Father's Name (First, Middle, Last): Edward William Brooks
18. Mother's Name (First, Middle, Maiden Surname): Lillian May Hale
19a. Informant's Name/Relationship (Type, Print): Ruth E. Wales/cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Caroline Drive, Middletown, Maryland 21769
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 615 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Dehydration

Due to (or as a consequence of):
b. Malnutrition

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Dementia Advanced

Due to (or as a consequence of):
d. Alzheimer's Disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) assisted living

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D51639
29d. Date signed (Month, Day, Year): 2-25-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06209

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): **Hazel Mary Bartelt**

2. Date of Death (Month Day Year): February 27, 1999

3. Time of Death: 4:15 PM

4a. Facility Name (If not institution, give street and number): Lorien Nursing Home

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 318-26-3941

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): April 1, 1903

9. Birthplace (State or Foreign Country): Indiana

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6138 Camelback Lane

10f. Zip Code: 21045

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson

16b. Kind of Business/Industry: Sales

17. Father's Name (First, Middle, Last): Matthew Klein

18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): Mr. Charles Bartelt Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6138 Camelback Lane Columbia, Maryland 21045

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory | Date: 03/01/99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature] M00535

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. Congestive heart failure — Approximate Interval Between Onset and Death: years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D04 345

29d. Date signed (Month, Day, Year): March 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles E. Taylor MD 2 Knoll North Drive, Columbia MD 21045

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06210

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GILBERT T. CLARK
2. Date of Death: Month February Day 26 Year 1999
3. Time of Death: 10 25 AM
4a. Facility Name (If not institution, give street and number): Liberty Medical Center BALTIMORE 21215
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 216-16-9751
6. Sex: 1 [X] M 2 [ ] F
7. Age (in yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08 28 24
9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3915 Calloway Ave apt 712
10f. Zip Code: 21215
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): 2 yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Ware-House Man
16b. Kind of Business/Industry: Civil Service
17. Father's Name (First, Middle, Last): Blancoe Johnson
18. Mother's Name (First, Middle, Maiden Surname): Myrtle Williams
19a. Informant's Name/Relationship (Type, Print): Margaret G. Clark -Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3915 Calloway Ave Apt 712, Baltimore Md 21215
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet
Date: 3/4/99
20c. Location - City or Town, State: Owings Mills, Md
21. Signature of Funeral Service Licensee: John B. Johnson Jr.
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. UROSEPSIS, PNEUMONIA	2/20/99
Due to (or as a consequence of):	b. Electrolytes Imbalance	2/20/99
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Dehydration	2/20/99
Due to (or as a consequence of):	d. Renal Failure	unknown

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Kwang N. Kim MD
29c. License number: D17031
29d. Date signed (Month, Day, Year): February 26 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KWANG N. KIM. MD. 2600 Liberty Heights BALTIMORE. MD. 21215

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Penny B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Items: 5,17,18 per F.H G-769 3/9/99 reb

Certificate of Death

Reg. No. 99 06211

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kenneth M Chapman
2. Date of Death (Month, Day, Year): Feb 28 1999
3. Time of Death: 12:30pm
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 140-30-~~4171~~ 4571
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11 06 39
9. Birthplace (State or Foreign Country): N.J.

Usual Residence of Decedent

10a. State: Md
10b. County: Anne Arundel Co
10c. City, Town or Location: Severn
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7893 Pavilion Drive
10f. Zip Code: 21144
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Post Office
16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last): ~~Unknown~~ Markham Garfield Chapman
18. Mother's Name (First, Middle, Maiden Surname): ~~Estelle Darvin~~ Estella Mae Gorham

19a. Informant's Name/Relationship (Type, Print): Hattie Chapman-Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7893 Pavilion Dr, Severn Md 21144

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville Vet
Date: 3/4/99
20c. Location - City or Town, State: Crownsville, Md

21. Signature of Funeral Service Licensee: Lynette K. Jones
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. coronary vascular disease — Approximate Interval Between Onset and Death: years

Due to (or as a consequence of): b. diabetes mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c. hypertension

Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeffrey Briggs MD
29c. License number: D28640
29d. Date signed (Month, Day, Year): Feb 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P.O. BOX 28 Crownsville MD 21032

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20+1 pgh

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06212

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TYRONE CHURCHILL
2. Date of Death (Month, Day, Year): FEBRUARY 27, 1999
3. Time of Death: 10:30 AM
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-54-1759
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): FEB 27 1951
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: XX Yes 2☐ No
10e. Street and Number: 1331 WOODYEAR STREET
10f. Zip Code: 21217
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade | College (1-4or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FORK LIFT OPERATOR
16b. Kind of Business/Industry: DAVID C JOSEPH & CO

17. Father's Name (First, Middle, Last): ALBERT E CHURCHILL
18. Mother's Name (First, Middle, Maiden Surname): THELMA A CARTER CHURCHILL

19a. Informant's Name/Relationship (Type, Print): Sheila Churchill/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1331 Woodyear Street, Baltimore Maryland 21217

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL
Date: 3-3-99
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Barbara A Brown
22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. BRAIN HERNIATION — 3 days
Due to (or as a consequence of):
b. RIGHT HEMISPHERIC STROKE — 7 days
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CORONARY HEART DISEASE
HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: P09977
29d. Date signed (Month, Day, Year): FEBRUARY 27, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARMEN CASTRILLO, MD 22 SOUTH GREENE STREET BALTIMORE, MARYLAND 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ B. Apostol

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 06213

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gertrude Connolly
2. Date of Death (Month, Day, Year): February 26 1999
3. Time of Death: 07:12am
4a. Facility Name *(If not institution, give street and number)*: Mercy Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: City

Funeral Director

5. Social Security Number: 212-18-9038
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 17, 1920
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Abingdon
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 500 Ramblewood Road, Apt. 102
10f. Zip Code: 21009
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th grade — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerical
16b. Kind of Business/Industry: Furniture Store
17. Father's Name *(First, Middle, Last)*: John Charles Kelly
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Gertrude McNanay
19a. Informant's Name/Relationship *(Type, Print)*: Joan M. Wagoner (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 1505, Fort Ashby, West Virginia 26719
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery — Date: 3/2/99
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: ▶ Robert Woodcock
22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Karen A. Kozak MD

29c. License number: D40744

29d. Date signed *(Month, Day, Year)*: February 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K.A. Kozak. Mercy Hospital 301 So. Paul Pl. Balto, MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 02 1999

32. Registrar's Signature: ▶ Benita G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06214

COHEN, ANITA 2-23-99 @ 8:00PM

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): ANITA KRIEGER COHEN
2. Dete of Deeth (Month, Day, Year): FEBRUARY 23, 1999
3. Time of Death: 8:00 PM
4e Feciility Neme (If not institution, give street end number): HOSPICE OF BALTIMORE GILCHRIST CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-28-6069
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 69 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): AUG. 12, 1929
9. Birthpiece (State or Foreign Country): MD

Usuel Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 8047 WOODGATE CT. #B
10f. Zip Code: 21244
10g. Citizen of Whet Country?: U.S.A.
11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): CLAIMS ADUSTER
16b. Kind of Business/Industry: SOCIAL SECURITY
17. Fether's Name (First, Middle, Last): HARRY KRIEGER
18. Mother's Name (First, Middle, Maiden Surneme): REBA NAGELBLATT
19e. Informent's Name/Reletionship (Type, Print): SUSAN ENDLER / DAUGHTER
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 4 MULRANY COURT - TIMONIUM, MD 21093
20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): MIKRO KODESH BETH ISRAEL
Date: 2/25/99
20c. Location - City or Town, Stete: BALTIMORE, MD
21. Signature of Funeral Service Licensee: ▶
22. Name end Address of Feciility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Immediate Cause (Final diseese or condition resulting in death) e. Breast Concer — Approximete Intervel Between Onset and Deeth: years

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest

b.

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveiiebie prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piace of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Naturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certier (Check only one): 1☒ **Certifying Phyeicien:** To the best of my knowiedge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signeture and title of certifier: ▶ J. Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Dey, Year): February 24, 1999

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): W.A. Riley GBHC 6701 N. Charles St. Balto. Md 21204

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

10

State Registrar

31. Dete filed (Month, Dey, Year): MAR 2 - 1999
32. Registrar's Signeture: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06215

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert A. Cook
2. Date of Death (Month, Day, Year): February 20, 1999
3. Time of Death: 9:50a.m.
4a. Facility Name (If not institution, give street and number): 5305 Chrysler Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 223-22-6417
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 14, 1921
9. Birthplace (State or Foreign Country): Va.

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5305 Chrysler Avenue
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steel Worker
16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middle, Last): William Cook
18. Mother's Name (First, Middle, Maiden Surname): Ruth Clark

19a. Informant's Name/Relationship (Type, Print): David Cook son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12326 Hatton Point Road Fort Washington, Md. 20744

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery
Date: Feb. 27
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ D. Prince Waters
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARRHYTHMIA — 1 min.

Due to (or as a consequence of):
b. METASTATIC CARCINOMA PROSTATE — >4 yr.

Due to (or as a consequence of):
c. CARCINOMA BLADDER — >4 yr.

Due to (or as a consequence of):
d. DIABETES MELLITUS — >2 yr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) HOSPICE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Michael L. Leiu MD
29c. License number: D-06055
29d. Date signed (Month, Day, Year): 2/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL L LEIU MD 4000 OLD COURT RD BALTO 21208 MD

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06216

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN BESSIE CHERRY
2. Date of Death: Month FEB. Day 25 Year 1999
3. Time of Death: 9:05 P.M.
4e. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-20-5754
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 72 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 10, 1926
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10e. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3726 RASPE AVENUE
10f. Zip Code: 21206
10g. Citizen of What Country? U.S.A.
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+): N/A
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRINTING PRESSER
16b. Kind of Business/Industry: PRINTING
17. Father's Name (First, Middle, Last): CHARLES LEE YOUNKER
18. Mother's Name (First, Middle, Maiden Surname): MARY WARD FLEMING
19e. Informant's Name/Relationship (Type, Print): CHARLES LEE CHERRY
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2605 THORNY DRIVE CHURCHVILLE, MD 21028
20e. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARDENS OF FAITH CEMETERY
Date: MAR 3, 1999
20c. Location - City or Town, State: ROSEDALE, MD
21. Signature of Funeral Service Licensee: Robert E. Altenburg D00002
22. Name and Address of Facility: 6009 HARFORD RD ALTENBURG FUNERAL HOME, P.A. BALTIMORE, MD 21214

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
c. HYPERTENSION
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marcia M. Mennucci MD
29c. License number: D076 97
29d. Date signed (Month, Day, Year): 3/1/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 7505 OSLER DR #301 TOWSON, MD 21204

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06217

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leroy Davis
2. Date of Death: Month Feb, Day 24, Year 99
3. Time of Death: 4:45 A
4a. Facility Name (If not institution, give street and number): Bon Secour
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 249-74-9607
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 52 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/7/46
9. Birthplace (State or Foreign Country): USA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4633 Manordene Rd
10f. Zip Code: 21229
10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck
16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): unk.
18. Mother's Name (First, Middle, Maiden Surname): Mary L. Parker

19a. Informant's Name/Relationship (Type, Print): Nancy Sligh-Smith/sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 430 Rosecroft Terrace Balto, MD 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mant Zion
Date: 3/4/99
20c. Location - City or Town, State: Lansdowne, MD

21. Signature of Funeral Service Licensee: Gary P. March
22. Name and Address of Facility: Gary P. March F.H. P.A. 270 Fredhilton Pass Balto, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acquired Immunodeficiency Syndrome
Due to (or as a consequence of):
b. Ischemic Bowel disease
Due to (or as a consequence of):
c. Septicemia
Due to (or as a consequence of):
d. Respiratory Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Endstage renal disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D18329
29d. Date signed (Month, Day, Year): 2/24/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Moges Gebremariam 4660 Wilkens Ave Balto 21229

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06218

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN M. DAVIS
2. Date of Death: Month FEB Day 24 Year 1999
3. Time of Death: 2:30 p.m.
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-10-7064
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03/25/1914
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1215 CARROLL STREET
10f. Zip Code: 21230
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LEGAL SECRETARY
16b. Kind of Business/Industry: LAW
17. Father's Name (First, Middle, Last): HOWARD DAVIS
18. Mother's Name (First, Middle, Maiden Surname): CARRIE YENTNER
19a. Informant's Name/Relationship (Type, Print): MICHAEL DAVIS/NEPHEW
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 315 ROBINSON ST. SUITE 580 ORLANDO, FL 32801
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY — Date: 2/27/99
20c. Location - City or Town, State: BALTIMORE, MD
21. Signature of Funeral Service Licensee: ▶ Mary K. Marshall
22. Name and Address of Facility: STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. SEPSIS	2 DAYS.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. HTN. = HYPERTENSION	20 YEARS
Due to (or as a consequence of):		
	c. DEPRESSION	5 YEARS
Due to (or as a consequence of):		
	d. CARDIO-VASCULAR EPISODE	24 YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] M.D.
29c. License number: P 12592
29d. Date signed (Month, Day, Year): Feb 24 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAKSYMILIAN KOWALKO 500 CATON AVE, BALTIMORE MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME DAVIS EVELYN

3

State Registrar

31. Date filed (Month, Day, Year)
32. Registrar's Signature ▶

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 99 06219

State of Maryland / Department of Health and Mental Hygiene

Item#19a perFHG769 3/4/99EW

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alvin · Davis
2. Date of Death (Month Day Year): Feb. 25, 99
3. Time of Death: 5:00am
4a. Facility Name (If not institution, give street and number): Irvington Knolls Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 249-50-6425
6. Sex: 1 ☐ M 2 ☐ F (X M)
7. Age (In yrs. last birthday): 61 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02-18-38
9. Birthplace (State or Foreign Country): GA

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No (X Yes)
10e. Street and Number: 3213 Elmora Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed (X) 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No (X Yes) If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No (X No) Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade — College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Longshoreman
17. Father's Name (First, Middle, Last): Rocelis Callaway
18. Mother's Name (First, Middle, Maiden Surname): Janie Davis
19a. Informant's Name/Relationship (Type, Print): ~~Blache~~ Blanche Johnson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1642 Chilton Street Baltimore, Maryland 21218
20a. Method of Disposition: 1 ☐ Burial (X) 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest VA Cem. — Date: 03-02-99
20c. Location - City or Town, State: Owings Mills, MD
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: WM.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. End stage renal disease — Approximate Interval Between Onset and Death: year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. End stage AIDS

Due to (or as a consequence of):

c. –

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: History of Deep Venous thrombosis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown (X)

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No (X)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No (X)

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No (X)

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient (X) 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural (X) 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ Certifying Physician (X): To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Amatun H. Naeem MD
29c. License number: D15503
29d. Date signed (Month, Day, Year): 3, 1, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 501 Dolphin Street Baltimore MD 21217

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item#9 perFH G769 3/2/99 EW

Certificate of Death

Reg. No. 99 06220

Patient Known As: Beckelbaum, Evelyn

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN A. DECKELBAUM
2. Date of Death: Month February Day 25 Year 1999
3. Time of Death: 0901 AM
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-16-9334
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 16 1920
9. Birthplace (State or Foreign Country): Pennsylvania ~~PENNSYLPA~~

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7408 KATHYDALE ROAD
10f. Zip Code: 21208
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): SAMUEL ARONOFF
18. Mother's Name (First, Middle, Maiden Surname): ANNA ARNOW

19a. Informant's Name/Relationship (Type, Print): STEVEN DECKELBAUM / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7408 KATHYDALE ROAD - BALTIMORE, MD 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH TFILOH CEMETERY
Date: 2/28/99
20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service License: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Breast Cancer, Lung Cancer

Due to (or as a consequence of):
b. Hypernatremia

Due to (or as a consequence of):
c. Eaton-Lambert Syndrome

Due to (or as a consequence of):
d. Sepsis, Pneumonia

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: P12340
29d. Date signed (Month, Day, Year): February 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Otis Stephens, MD Sinai Hospital of Baltimore 2401 W Belvedere Ave.

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature] B. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06221

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kaitlyn Nicole deLaubenfels
2. Date of Death (Month Day Year): February 25 1999
3. Time of Death: 2109
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center Clatanoff Pavilion
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: A.A.

Funeral Director

5. Social Security Number: 888-34-6590
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours 11 / Min.
8. Date of Birth (Month, Day, Year): 02/25/99
9. Birthplace (State or Foreign Country): md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Queene Anne
10c. City, Town or Location: Chester
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 305 Skippers Lane
10f. Zip Code: 21619
10g. Citizen of What Country? USA

11. Meritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12) / College (1-4or 5+)
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)
16b. Kind of Business/Industry

17. Father's Neme (First, Middle, Last): Eric Arthur deLaubenfels
18. Mother's Name (First, Middle, Maiden Surname): Martha Patricia Henley

19e. Informant's Neme/Reletionship (Type, Print): Eric DeLaubenfels - Father
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 305 Skipper Lane, Chester, MD 21619

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other place): Metro Crematory — Date: 03/02
20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: Thomas N Hardesty
22. Name end Address of Fecility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Immediate Cause (Finel diseese or condition resulting in deeth) a. Extreme prematurity — Approximate Interval Between Onset and Death: 11 hrs

Due to (or as a consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet Initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

severe metabolic acidosis

prolapsed umbilical cord

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: Suzanne Rindfleisch DO
29c. License number: H42733
29d. Date signed (Month, Day, Year): February 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suzanne Rindfleisch D.O. 2001 Medical Pkwy Annapolis, MD 21401

State Registrar

31. Dete filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signeture

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

99-1053-510
B.K.S
ROY DOTSON
ITEMS: #23 PART I, 27, 28A-F PER MEO G769 3-5-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

WR. Reg. No. 99 06222

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Roy Herndon Dotson, Jr.
2. Date of Death (Month, Day, Year): FEB. 23, 1999
3. Time of Death: 9:10 AM
4a. Facility Name (If not institution, give street and number): 1528 McCULLOH STREET 2ND FLOOR
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a
5. Social Security Number: 216-62-4680
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 44 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 16, 1955
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1528 McCulloh Street 2nd floor
10f. Zip Code: 21217
10g. Citizen of What Country?: USA
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th Grade — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Unknown
17. Father's Name (First, Middle, Last): Roy H. Dotson, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Cynthia Braxton
19a. Informant's Name/Relationship (Type, Print): Parents Cynthia Ligon / Roy Dotson, Sr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1528 McCulloh Street Baltimore, Md. 21217 2nd Fl.
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery — Date: March 2
20c. Location - City or Town, State: Baltimore, Md.
21. Signature of Funeral Service Licensee: D. Prince Waters
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. COCAINE AND NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined

28a. Date of Injury (Month, Day, Year): Found: 2-23-99
28b. Time of Injury: Found: 8:25 A M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND AT RESIDENCE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1528 McCULLOH STREET BALTIMORE, MARYLAND

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): FEB. 23, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: Barbara B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06223

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Doron
2. Date of Death (Month, Day, Year): February 22, 1999
3. Time of Death: 6:05 p.m.
4a. Facility Name (If not institution, give street and number): Mariner Overlea Nursing Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-07-6487
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 31, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6211 Everall Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Clerk
16b. Kind of Business/Industry: A&P
17. Father's Name (First, Middle, Last): Charles Davidson
18. Mother's Name (First, Middle, Maiden Surname): Emma Semilock
19a. Informant's Name/Relationship (Type, Print): Edna Ellrich
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6211 Everall Avenue Baltimore, Maryland 21206
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 2/25/99
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Chronic obstructive Pulmonary disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cerebral vascular accident pernicious anemia Hypothyroidism, Morbid obesity, Dementia Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Joseph D'Antonio Jr. MD.
29c. License number: D 22409
29d. Date signed (Month, Day, Year): 2/27/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Joseph D'Antonio , Jr 7401 Osler Dr Suite 201 Towson MD 21204

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: ▶ [signature]

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Dinah Eaton
crn
99-1178-510

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06224

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Dinah A. Eaton
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 3:30 A.M.
4a. Facility Name (If not institution, give street and number): Liberty Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A
5. Social Security Number: 218-62-9642
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 43 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-16-1955
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2711 W. North Avenue
10f. Zip Code: 21216
10g. Citizen of What Country?: U.S.A
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade — College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Line Worker
16b. Kind of Business/Industry: G+E
17. Father's Name (First, Middle, Last): Jerome M. Eaton
18. Mother's Name (First, Middle, Maiden Surname): Jessie Lawson
19a. Informant's Name/Relationship (Type, Print): Jessie Eaton - Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2711 W. North Avenue Baltimore, Md 21216
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Western Star Cemetery — Date: 2-15-99
20c. Location - City or Town, State: Catonsville, Md
21. Signature of Funeral Service Licensee: Jerome A. Thompson
22. Name and Address of Facility: March F. H. West, 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Bilateral Pneumonia / Septicemia
Due to (or as a consequence of): b. Pulmonary Embolism
Due to (or as a consequence of): c. Status post thoracotomy / wedge resection
Due to (or as a consequence of): d. Empyema - pleural effusion

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Narcotism, Anemia

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): 3-1-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Lawrence Locke, MD — 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2 pgs

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06225

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDith ENNIS
2. Date of Death (Month, Day, Year): February 26, 1999
3. Time of Death: 10 PM
4a. Facility Name (If not institution, give street and number): St Agnes Nsg. & Rehab. 3000 N Ridge Rd.
4b. City, Town, or Location of Death: Ellicott City
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 212-07-1006
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 10, 1920
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7070 Cradlerock Way
10f. Zip Code: 21045
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Dry Cleaning/Tailoring
17. Father's Name (First, Middle, Last): Graham Carneal
18. Mother's Name (First, Middle, Maiden Surname): Sadie Noel
19a. Informant's Name/Relationship (Type, Print): Marian Bruno (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13791 Highland Road, Clarksville, MD 21029
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park | Date: 3/3/99
20c. Location - City or Town, State: Elkridge, MD
21. Signature of Funeral Service Licensee: ▶ Robert Guy Burba
22. Name and Address of Facility: Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, MD 21045

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARCINOMA of Right lung — 4 years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Chronic obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ N B Vellanki
29c. License number: D. 30469
29d. Date signed (Month, Day, Year): February 28, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N.B. VELLANKI, MD. 9055 CHEVROLET DRIVE #100 ELLICOTT CITY MD. 21042

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: Bernice G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06226

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELSIE PRESTON FRANKENFIELD
2. Date of Death (Month, Day, Year): FEBRUARY 24, 1999
3. Time of Death: 5:50PM
4a. Facility Name (If not institution, give street and number): 10 HILLVIEW DRIVE
4b. City, Town, or Location of Death: CATONSVILLE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 161-20-8215
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03/23/1925
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: CATONSVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10 HILLVIEW DRIVE
10f. Zip Code: 21228
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME
17. Father's Name (First, Middle, Last): JOHN PRESTON
18. Mother's Name (First, Middle, Maiden Surname): GERTRUDE EVERS
19a. Informant's Name/Relationship (Type, Print): CARL FRANKENFIELD/HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 HILLVIEW DRIVE CATONSVILLE, MD 21228
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LAKE VIEW MEMORIAL PARK
Date: 2/27/99
20c. Location - City or Town, State: SYKESVILLE, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ADENOCARCINOMA, UNDETERMINED SOURCE — 3 MOS

Due to (or as a consequence of): METASTATIC TO LIVER, LUNGS, CERVICAL SPINE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. _____ Due to (or as a consequence of):

c. _____ Due to (or as a consequence of):

d. _____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Laurence R Gallagher, MD

29c. License number: D01786

29d. Date signed (Month, Day, Year): FEB 26 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LAURENCE R. GALLAGER, MD 716 MAIDENCHOICE LANE, BALTO MD. 21228

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999

32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06227

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN, FREDERICK
2. Date of Death: Month 02 Day 24 Year 1999
3. Time of Death: 8:20PM
4a. Facility Name (If not institution, give street and number): Mercy Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-03-4958
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov.7,1917
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1007 Crosby Road
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Walter Burke
18. Mother's Name (First, Middle, Maiden Surname): Margaret Tyrell

19a. Informant's Name/Relationship (Type, Print): Linda Happel/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4253 Cezanne Circle, Ellicott City,Md21042

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crestlawn Mem Gardens | Date: 3/1
20c. Location - City or Town, State: Marriottsville,Md

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. DIFFUSE MALIGNANT LARGE BCELL LYMPHOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

OSTEOARTHRITIS, GLAUCOMA
HYPERCHOLESTEROLEMIA

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mark Kim, MD
29c. License number: P10226
29d. Date signed (Month, Day, Year): 02/24/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARK KIM, MD MERCY MEDICAL CENTER, 301 ST. PAUL PLACE, BALTIMORE MD

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ [signature]

8

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06228

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELLIS M. FELL
2. Date of Death: Month FEBRUARY Day 23 Year 1999
3. Time of Death: 10:57 AM
4e. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 217-20-3076
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 93 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 25, 1905
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6 KNOLL RIDGE COURT #1411
10f. Zip Code: 21210
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MILITARY OFFICER
16b. Kind of Business/Industry: U.S. NAVY

17. Father's Name (First, Middle, Last): LOU FELL
18. Mother's Name (First, Middle, Maiden Surname): FANNIE ROSEN

19e. Informant's Name/Relationship (Type, Print): ALAN FELL / SON
19f. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13201 DOVER ROAD - REISTERSTOWN, MD 21136

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HAR SINAI CEMETERY
Date: 2/26/99
20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. sepsis	72 hours
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. myocardial infarction	24 hours
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] DO KLEIN MD resident physician
29c. License number: 98039
29d. Date signed (Month, Day, Year): February 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Drake Klein, MD Johns Hopkins Bayview medical center

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature] B. Sparks

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Replacement

Certificate of Death

Reg. No. 99-06229

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALPHONSO E. FRANKLIN
2. Date of Death: Month FEBRUARY Day 25 Year 1999
3. Time of Death: 4:55 PM
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-92-7475
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 32 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/11/66
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 9408 Jodale Rd.
10f. Zip Code: 21133
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: N / A

17. Father's Name (First, Middle, Last): Alphonso E. Franklin Sr.
18. Mother's Name (First, Middle, Maiden Surname): Susie O. Speights

19a. Informant's Name/Relationship (Type, Print): Alphonso E. Franklin Sr. [Father]
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 940B Jodale Rd., Randallstown, Md. 21133

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 2/27/99
20c. Location - City or Town, State: Catonsville, Md.

21. Signature of Funeral Service Licensee: per V.R ▶ Charlene Brown
22. Name and Address of Facility: Joseph H. Brown Jr. Funeral Home, 2140 N. Fulton Ave. Baltimore, Md.21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. anoxia — 5 days
Due to (or as a consequence of):
b. cardiac arrest — 5 days
Due to (or as a consequence of):
c. AIDS — 5 years
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] Resident physician
29c. License number: P10212
29d. Date signed (Month, Day, Year): MARCH 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. NAZARIAN M.D. 22 SOUTH GREENE STREET BALTIMORE, MD 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 10 1999
32. Registrar's Signature: ▶ [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06230

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DORIS GRIFFIN
2. Date of Death (Month, Day, Year): FEBRUARY 28, 1999
3. Time of Death: 9:35 PM
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-58-6831
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 48 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUL 8 1950
9. Birthplace (State or Foreign Country): D.C.

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: CHASE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 39 AKIN CIRCLE
10f. Zip Code: 21220
10g. Citizen of What Country?: U.S.A.

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: DOMESTIC
17. Father's Name (First, Middle, Last): ROBERT C MOODY
18. Mother's Name (First, Middle, Maiden Surname): DOROTHY ROOK NEWMAN
19a. Informant's Name/Relationship (Type, Print): Jesse Griffing/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 39 Akin Circle, Baltimore, Maryland 21220
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN CEMETERY
Date: 3-4-99
20c. Location - City or Town, State: WOODLAWN, MARYLAND
21. Signature of Funeral Service Licensee: Barbara A. Brown
22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME, 1206 W NORTH AVENUE, PA

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ELECTROLYTE ABNORMALITIES	2 WEEKS
Due to (or as a consequence of):	b. DISSEMINATED METASTATIC ADENOCARCINOMA	2 MONTHS
Due to (or as a consequence of):	c.	
Due to (or as a consequence of):	d.	

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Shalini Tewari

29c. License number: 96118

29d. Date signed (Month, Day, Year): February 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shalini Tewari, JOHNS HOPKINS BAYVIEW MEDICAL CENTER, 4940 EASTERN AVENUE, BALTIMORE, MD 21224

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999

32. Registrar's Signature: Lewis B. Spaks

3 PEB

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06231

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eleanore E. Grabowski
2. Date of Death: Month 02 Day 28 Year 1999
3. Time of Death: 2:45P.M
4a. Facility Name (If not institution, give street and number): Genesis Eldercare Severna Park Center
4b. City, Town, or Location of Death: Severna Park
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 282-10-6183
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months Days | If Under 24 Hrs.: Hours Min.
8. Date of Birth (Month, Day, Year): 11-12-1915
9. Birthplace (State or Foreign Country): Cleve. Ohio

Usual Residence of Decedent

10a. State: Ohio
10b. County: Cuyahoga
10c. City, Town or Location: Parma Heights
10d. Inside City Limits: 1☐ Yes 2☐ No X
10e. Street and Number: 9454 Greenbriar Drive.
10f. Zip Code: 44130
10g. Citizen of What Country? USA

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed X 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No X If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No X Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 12th; College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Music
16b. Kind of Business/Industry: Retail Sales
17. Father's Name (First, Middle, Last): Otto Hlad
18. Mother's Name (First, Middle, Maiden Surname): Anna Straka
19a. Informant's Name/Relationship (Type, Print): Elaine Grabowski
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21666: 314 Queen Anne Club Drive Stevensville, MD
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): All Saints Cemetery
Date: 3-6-1999
20c. Location - City or Town, State: Northfield, Ohio
21. Signature of Funeral Service Licensee: ▶ Mary K. Marshall
22. Name and Address of Facility: Sterling-Ashton-Schwab Funeral Home Inc. 736 Edmondson Ave. Catonsville, Md 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Gastrointestinal bleeding — Approximate Interval Between Onset and Death: 2 weeks
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive heart failure
Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ M Ochaney MD
29c. License number: D-40521
29d. Date signed (Month, Day, Year): February 28, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. OCHANEY 3350 Wilkens Avenue Suite 302 Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ [illegible]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ELEANOR GRABOWSKI

DHMH 16 Rev 6/95

RKD

99-1130-510

LEANORA GROSS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06232

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEANORA MARIAN GROSS
2. Date of Death (Month, Day, Year): FEBRUARY 26, 1999
3. Time of Death: 8:37P.M.
4a. Facility Name (If not institution, give street and number): 2501 VIOLET AVE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-18-5525
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 18, 1924
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2501 VIOLET AVENUE, APT. #404
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC WORKER
16b. Kind of Business/Industry: UNKNOWN

17. Father's Name (First, Middle, Last): PRESTON JOHNSON
18. Mother's Name (First, Middle, Maiden Surname): ELIZABETH MASON

19a. Informant's Name/Relationship (Type, Print): VERONICA JOHNSON (SISTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4117 HAYWARD AVENUE, BALTIMORE, MD. 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST
Date: 03-05-99
20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: ▶ John F. Hutchison Jr.
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME, 2140 N. FULTON AVE., BALTIMORE, MD. 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? INSPECTION 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): FEBRUARY 27, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DAVID R. FOWLER MD. 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ Linda G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06233

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lewis H. Hill
2. Date of Death: Month 2 Day 20 Year 1999
3. Time of Death: 10:00 P.M
4a. Facility Name (If not institution, give street and number): 2312 Longwood Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 257-18-7028
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 81 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-19-1917
9. Birthplace (State or Foreign Country): Ga

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2312 N. Longwood Street
10f. Zip Code: 21216
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middle, Last): Birl D. Hill
18. Mother's Name (First, Middle, Maiden Surname): America Easley

19a. Informant's Name/Relationship (Type, Print): Ruby Hill - wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2312 N. Longwood Street Balto, Md 21216

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet
Date: 3-4-99
20c. Location - City or Town, State: Owings Mills, Md

21. Signature of Funeral Service Licensee: ▶ Dale March
22. Name and Address of Facility: March F.H. West 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. COLON CANCER — 1½ YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PARKINSON'S DISEASE

CORONARY ARTERY DISEASE

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D38409
29d. Date signed (Month, Day, Year): 2/22/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WM SHMEFMAN 4940 EASTERN AVE BALTIMORE, MD 21224

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15+1

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06234

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jennette Ellen Hall
2. Date of Death (Month, Day, Year): February 28 1999
3. Time of Death: 2:12 pm
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-26-4877
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 15, 1930
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 501 Dolphin Street
10f. Zip Code: 21217
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Albert P. Hall
18. Mother's Name (First, Middle, Maiden Surname): Catherine Johnson

19a. Informant's Name/Relationship (Type, Print): Joyce R. Butler - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1823 Lanvale St. Baltimore, Maryland 21217

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 3-5-99
20c. Location - City or Town, State: Lansdowne, MD

21. Signature of Funeral Service Licensee: Gerald F. March
22. Name and Address of Facility: Gary P. March Funeral Home, P.A. 270 Fredhilton Pass, Balto., MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Arrhythmia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John G. Bentley
29c. License number: P12668
29d. Date signed (Month, Day, Year): 2/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John G. Bentley, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: B. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Jennette Hall

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

99-1120-005
crn
James Hannah

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

3-11-99 WR

ITEMS: #23 PART I, 27, 28A-F PER MEO G769

Certificate of Death

Reg. No. 99 06235

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): James Richard Hannah
2. Date of Death (Month, Day, Year): February 26, 1999
3. Time of Death: 9:35 A.M.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore
5. Social Security Number: 412-57-2092
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 25 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02-25-1974
9. Birthplace (State or Foreign Country): Chattan. TN

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8837 Trimble Way
10f. Zip Code: 21237
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Construction
17. Father's Name (First, Middle, Last): Terry W. Hannah - Father
18. Mother's Name (First, Middle, Maiden Surname): Patricia Smith Russell
19a. Informant's Name/Relationship (Type, Print): Terry W. Hannah/ Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4307 12th Chattanooga, TN 37407
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fuller Cemetery
Date: 3/3/99
20c. Location - City or Town, State: Ider, AL
21. Signature of Funeral Service Licensee: Mary K. Marshall
22. Name and Address of Facility: Sterling-Ashton-Schwab Funeral Home Inc. 736 Edmondson Ave. Catonsville Md, 21228

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC INTOXICATION
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined

28a. Date of Injury (Month, Day Year): Found: 2/2699
28b. Time of Injury: Found: 8:54 A M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND AT RESIDENCE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 8837 TRIMBLE WAY BALTIMORE, MARYLAND

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): February 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: Bernice B. Arnold

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06236

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Howard M. Harris
2. Date of Death (Month, Day, Year): Feb. 24 1999
3. Time of Death: 9:30 PM
4a. Facility Name *(If not institution, give street and number)*: UNION MEMORIAL HOSP.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 578-01-5801
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT 16 1917
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7516 PRINCE GEORGE RD.
10f. Zip Code: 21208
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) — College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PROPRIETOR
16b. Kind of Business/Industry: HARDWARE

17. Father's Name *(First, Middle, Last)*: PHILLIP HARRIS
18. Mother's Name *(First, Middle, Maiden Surname)*: SARAH APPLESTEIN

19a. Informant's Name/Relationship *(Type, Print)*: RUTH HARRIS (WIFE)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7516 PRINCE GEORGE RD. BALTO.,MD 21208

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: LUBAWITZ NUSACH ARI (NER TAMID) — Date: 2/25/99
20c. Location - City or Town, State: ROSEDALE, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — 7 days
Due to (or as a consequence of):
b. Cellulitis — 7 days
Due to (or as a consequence of):
c. Myelodysplastic Syndrome — 1 year
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: D44944
29d. Date signed *(Month, Day, Year)*: Feb 24, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STANLEY Walton M.D. 3333 North Calvert Street Baltimore MD 21218

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be prepared within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

HOWARD HARRIS

8

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 - 1999
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06237

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SANGWILL W HACKERMAN
2. Date of Death — Month: February Day: 25 Year: 1999
3. Time of Death: 6:37 PM
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 109-01-1814
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 11, 1915
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3601 FORDS LANE #601
10f. Zip Code: 21215
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: ARMY
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OFFICE WORKER
16b. Kind of Business/Industry: FEDERAL GOVERNMENT
17. Father's Name (First, Middle, Last): SAM HACKERMAN
18. Mother's Name (First, Middle, Maiden Surname): ROSE HACKEN
19a. Informant's Name/Relationship (Type, Print): JEANNETTE HACKERMAN / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3601 FORDS LANE #601 - BALTIMORE, MD 21215
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): TAMID LUBAWITZ NUSACH ARI NER — Date: 2/28/99
20c. Location - City or Town, State: ROSEDALE, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD
29c. License number: AS2402321-SL-9005
29d. Date signed (Month, Day, Year): February 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMUEL LEE, SINAI HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature]

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To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06238

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THEODORE HOENIG
2. Date of Death (Month, Day, Year): FEBRUARY 28, 1999
3. Time of Death: 2:07 AM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 068-01-1069
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 27, 1917
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: RANDALLSTOWN
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8408 BILLSON ROAD
10f. Zip Code: 21133
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PHOTOGRAPHER
16b. Kind of Business/Industry: U.S. ARMY
17. Father's Name (First, Middle, Last): ISIDORE HOENIG
18. Mother's Name (First, Middle, Maiden Surname): MINNIE HANDELSMAN
19a. Informant's Name/Relationship (Type, Print): EVELYN HOENIG / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8408 BILLSON ROAD - RANDALLSTOWN, MD 21133
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH TFILOH CEMETERY — Date: 2/28/99
20c. Location - City or Town, State: WOODLAWN, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Brainstem CVA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D14900
29d. Date signed (Month, Day, Year): February 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. J. IMPERIAL, JR. MD — NWHC

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature] B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06239

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Willie Winifred Hughes
2. Date of Death (Month, Day, Year): February 28, 1999
3. Time of Death: 7:50AM
4e. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 230-36-9241
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 29, 1931
9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10e. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Odenton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1230 Brietwert Avenue
10f. Zip Code: 21113
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance
16b. Kind of Business/Industry: INternational Paper
17. Father's Name (First, Middle, Last): James Eli Hughes
18. Mother's Name (First, Middle, Maiden Surname): Bessie Yeany
19a. Informant's Name/Relationship (Type, Print): Helen Marie Hughes - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1230 Brietwert Ave. Odenton, MD 21113
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cem.
Date: 3/3/99
20c. Location - City or Town, State: Crownsville, MD
21. Signature of Funeral Service Licensee: Thomas A Hardesty
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 ridgely Ave. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Pneumonia	2 weeks
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Emphysema	5 years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [✓] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elliot Gorbaty MD
29c. License number: 020094
29d. Date signed (Month, Day, Year): 2/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elliott Gorbaty MD / 7845 Oakwood Rd, Glen Burnie, Md. 21061

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Hughes, Willie

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item#11 perFHG770 4/13/99 EW

Certificate of Death

Reg. No. 99 06240

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUISE D. HEATHER
2. Date of Death (Month Day Year): FEB. 25 1999
3. Time of Death: 9:17am
4a. Facility Name (If not institution, give street and number): FUTURE CARE-CHESAPEAK N. HOME
4b. City, Town, or Location of Death: ANNAPOLIS
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 176-22-4014
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07/30/1916
9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MD
10b. County: ANNE ARUNDEL
10c. City, Town or Location: ANNAPOLIS
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 800 BESTGATE RD.
10f. Zip Code: 21401
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2YRS.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: HOMEMAKER

17. Father's Name (First, Middle, Last): PERRY DUNAWAY
18. Mother's Name (First, Middle, Maiden Surname): EMMA LOUISE PRICE

19a. Informent's Name/Relationship (Type, Print): RICHARD MAC HEATHER(SON)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 194 MAIN ST. GRANTSVILLE,MD. 21536.

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): DULANEY VALLEY MEM. — Date: 03/02/99
20c. Location - City or Town, State: TIMONIUM,MD.

21. Signature of Funeral Service Licensee: ▶ William R. Davis III
22. Name end Address of Fecility: HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finel disease or condition resulting in death) a. Acute Myocardial Infarction — Approximate Intervel Between Onset and Death: hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

dementia

depression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M Ochaney MD
29c. License number: D-40521
29d. Date signed (Month, Day, Year): February 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAYHESH OCHANEY M.D. 7845 OAKWOOD RD. SUITE 205 GLEN BURNIE,MD. 21601.

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06241

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: **Mary T. Hubschman**
2. Date of Death: Month Feb, Day 23, Year 99
3. Time of Death: 7am
4a. Facility Name *(If not institution, give street and number)*: St. Agnes Nursing & Rehab Center
4b. City, Town, or Location of Death: Ellicott City
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 089-24-5201
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: February 11, 1909
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3000 North Ridge Road
10f. Zip Code: 21043
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home
17. Father's Name *(First, Middle, Last)*: Martin Patwell
18. Mother's Name *(First, Middle, Maiden Surname)*: Nora O'Connor
19a. Informant's Name/Relationship *(Type, Print)*: Mr. John Hubschman Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9281 Soaring Hill Road Columbia, Maryland 21045
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Madonna Cemetery — Date: 02/25/99
20c. Location - City or Town, State: Fort Lee, New Jersey
21. Signature of Funeral Service Licensee: [signature] M00535
22. Name and Address of Facility: Hunt Stellato Funeral Home, 1601 Palisade Avenue Fort Lee, NJ 07024

To Be Completed by Funeral Director

Hubschman Mary Therese

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA — Approximate Interval Between Onset and Death: 1 week.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tasneem Lakhani
29c. License number: D28595
29d. Date signed *(Month, Day, Year)*: 2/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD 21208

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 02 1999
32. Registrar's Signature: [signature]

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06242

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IIONA HADLEY
2. Date of Death (Month, Day, Year): February 28, 1999
3. Time of Death: 1050A.
4a. Facility Name (If not Institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 041-36-6114
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 54 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 3, 1945
9. Birthplace (State or Foreign Country): Connecticutt

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No
10e. Street and Number: 23 Pepperdine Circle
10f. Zip Code: 21228
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): administrative assistant
16b. Kind of Business/Industry: mortgage company

17. Father's Name (First, Middle, Last): Alexander Sabo
18. Mother's Name (First, Middle, Maiden Surname): Martha Thorpe

19a. Informant's Name/Relationship (Type, Print): Mr. Glen Robinson Hadley Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 23 Pepperdine Circle Catonsville, Maryland 21228

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lake Grove Cemetery
Date: 03/05/99
20c. Location - City or Town, State: Holliston, MA

21. Signature of Funeral Service Licensee: [signature] 000585
22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ADULT RESPIRATORY DISTESS SYDRME — Approximate Interval Between Onset and Death: 2 weeks
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Flowers MD
29c. License number: D20789
29d. Date signed (Month, Day, Year): February 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Flowers MD 11055 Little Patuxent Columbia MD

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: [signature]

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06243

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Gwendolyn Johnson
2. Date of Death: Month February Day 27 Year 99
3. Time of Death: 11:55 AM
4a. Facility Name (If not institution, give street and number): Stella Maris at Mercy
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A
5. Social Security Number: 212-36-1865
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 64 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 19, 1935
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1615 E. Chase St.
10f. Zip Code: 21213
10g. Citizen of What Country? USA
11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Worker
16b. Kind of Business/Industry: School System
17. Father's Name (First, Middle, Last): Joseph Johnson Sr.
18. Mother's Name (First, Middle, Maiden Surname): Lizzella Johnson
19a. Informant's Name/Relationship (Type, Print): Ms. Sharon Porter (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2871 Chesterfield Ave. Balto. Md. 21213
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Mem. Gardens — Date: 3/5/99
20c. Location - City or Town, State: Dundalk, Md.
21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung CA
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Stella Maris Mercy Hospice
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Jal Thung m
29c. License number: D40854
29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl. BALTIMORE, MD 21202

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3 ROD

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06244

Jones, Alverta

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALVERTA JONES
2. Date of Death: Month Feb Day 24 Year 1999
3. Time of Death: 1630
4a. Facility Name (If not institution, give street and number): DEATON UNIVERSITY OF MARYLAND MEDICINE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-18-0080
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 01, 1923
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 611 S. CHARLES STREET
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): TALBOT F. RUSSELL
18. Mother's Name (First, Middle, Maiden Surname): GERTRUDE (MN-UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): VERNON HALL (COUSIN)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3712 W. BELVEDERE AVE., BALTIMORE, MD. 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY — Date: 03-03-99
20c. Location - City or Town, State: ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee: ▶ John L. Williams Jr.
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — Approximate Interval Between Onset and Death: 10 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Congestive heart failure — 4 yrs.

Due to (or as a consequence of):

c. Cerebro vascular accident — 4 yrs.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ C P Mehta MD
29c. License number: D34974
29d. Date signed (Month, Day, Year): Feb. 26. 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARU MEHTA, MD 8775 Cloudleap ct #224, Columbia, MD 21045

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ Linda B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item:5 per F.H G-769 3/26/99 reb

Certificate of Death

Reg. No. 99 06215

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Janie B. Jackson
2. Date of Death: Month 2 Day 25 Year 99
3. Time of Death: 11:57 Am
4a. Facility Name (If not institution, give street and number): UMMS Shock TRAUMA Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 214-30-3736A ~~214-22-6821~~
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 7, 1934
9. Birthplace (State or Foreign Country): S. Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1915 Gwynns Falls Parkway
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier
16b. Kind of Business/Industry: Dry Cleaner

17. Father's Name (First, Middle, Last): Hubert Halley
18. Mother's Name (First, Middle, Maiden Surname): Dessie Kelly

19a. Informant's Name/Relationship (Type, Print): Roland E. Jackson/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1915 Gwynns Falls Pkwy Baltimore, MD 21217

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. | Date: 2/27/99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Overwhelming Sepsis — 24 hours
Due to (or as a consequence of):
b. Respiratory failure
Due to (or as a consequence of):
c. massive myonecrosis
Due to (or as a consequence of):
d. Cardiovascular collapse

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus
Obesity

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N M Spriggs MD
29c. License number: AU417643S-S10123
29d. Date signed (Month, Day, Year): 2-25-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N M Spriggs MD UMMS Shock TRAUMA Center Baltimore, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 062L6

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Inez Keys
2. Date of Death (Month, Day, Year): FEBRUARY 27 1999
3. Time of Death: 09:40AM
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death:

Funeral Director

5. Social Security Number: 212-20-9205
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2 4 20
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 633 Aisquith St. Apt 10
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): housewife.
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Percy Lonesome
18. Mother's Name (First, Middle, Maiden Surname): Elizbeth UKN.

19a. Informant's Name/Relationship (Type, Print): Menerta Keys
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 405 Mistywood Way Apt. #I

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voschell
Date: 3/4/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jeff Miller
22. Name and Address of Facility: Jeff Miller P.C. Funeral Home & Services, 1639 N. Broadway Balto. Md. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive Pulmonary Disorder — Approximate Interval Between Onset and Death: 50 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Evelyn R Scott
29c. License number: RES-000
29d. Date signed (Month, Day, Year): February 27 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Evelyn Rene Scott Tower 110 Johns Hopkins Hospital Baltimore, 21202

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: B. Sparks

15

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Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06247

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Bernadette Kondner
2. Date of Death: Month Feb Day 25 Year 1999
3. Time of Death: 3:40 pm
4a. Facility Name (If not institution, give street and number): St. Agnes Healthcare
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: None

Funeral Director

5. Social Security Number: 213-48-1052
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 8, 1956
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3026 Hickorynede Drive
10f. Zip Code: 21042
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John B. Russell
18. Mother's Name (First, Middle, Maiden Surname): Mary E. Gerbig

19a. Informant's Name/Relationship (Type, Print): David Wm. Kondner Sr./Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3026 Hickorymede Drive Ellicott City, MD 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery | Date: 3-1-99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Sam A Collins-Witzke
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. metastatic breast cancer — 2 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Gabby Fossett, M.D.
29c. License number: D0052555
29d. Date signed (Month, Day, Year): February 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GABBY FOSSETT M.D. 900 Caton avenue Baltimore MD 21229

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

NAME Kondner, Mary

State Registrar

31. Data filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: ▶ Pearlena G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06248

NAME: KAESTNER, JOHN R.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN ROBERT KAESTNER
2. Date of Death (Month, Day, Year): FEBRUARY 25,1999
3. Time of Death: 2:03PM
4a. Facility Name (If not Institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 220-20-5835
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT.21 1927
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1900 CROMWELL BRIDGE RD.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elemantary/Secondary (0-12); College (1-4or 5+): 4YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): VICE PRES. A.E. KAESTNER
16b. Kind of Business/Industry: STAINLESS STEEL CO.

17. Father's Name (First, Middle, Last): ROBERT KAESTNER
18. Mother's Name (First, Middle, Maiden Surname): ALICE (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): ROBIN S. KAESTNER(DAUGHT)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 51 SPRING TIME WAY BALTIMORE,MD. 21234.

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PROSPECT HILL CEM.
Date: 03/01/99
20c. Location - City or Town, State: TOWSON,MD.

21. Signature of Funeral Service Licensee: ▶ William R. Jenkins III
22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Sepsis and Renal failure
Due to (or as a consequence of):
b. Rhabdomyolysis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Hassan Makhzoumi MD
29c. License number: D 22530
29d. Date signed (Month, Day, Year): 2-26-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HASSAN MAKHZOUMI 120 Sisk Avenue Towson

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06249

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret J. Kazmierski
2. Date of Death (Month, Day, Year): Feb. 26, 1999
3. Time of Death: 11:00am
4a. Facility Name (If not institution, give street and number): 1518 East Fort Avenue
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-60-3468
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 86 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 19, 1913
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1518 East Fort Avenue
10f. Zip Code: 21230
10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Dominic McDonnell
18. Mother's Name (First, Middle, Maiden Surname): Mary Mahoney

19a. Informant's Name/Relationship (Type, Print): Helen M. Bianca / Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1548 Latrobe Park Terrace, Baltimore Maryland 21230

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery, March 1, 1999
20c. Location - City or Town, State: Baltimore City

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Breast Cancer — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D40854
29d. Date signed (Month, Day, Year): 2/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Rusebery, MD 301 St Paul Pl Baltimore, MD 21202

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Items:19a,b per F.H G-769 3/23/99 rep /g.s
Item#7,8,17,18,20A-C perFH G769 3/22/99 EW
Amended#25,26 perPhyG769 3/2/99 EW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06250

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONALD L. KENNEDY
2. Date of Death (Month Day Year): January 9, 1999
3. Time of Death: 7:25 AM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 164-36-7938
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): ~~51~~ 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-30-46 ~~Dec. 31, 1947~~
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1402 Reynolds Street
10f. Zip Code: 21230
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Vietnam
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Parachute Rigger
16b. Kind of Business/Industry: Government
17. Father's Name (First, Middle, Last): ~~Unknown~~ Lloyd D. Kennedy
18. Mother's Name (First, Middle, Maiden Surname): ~~Unknown~~ Mary (Unknown)
19a. Informant's Name/Relationship (Type, Print): Annette M. Hamilton/Friend ~~Jason Kennedy/Son~~
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~unknown~~ 1402 Reynolds St. Baltimore, Md. 21230
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) ~~in state~~
20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville VA Cemetery
Date: 1/26/99
20c. Location - City or Town, State: Crownsville ,Md
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CORONARY VASCULAR DISEASE — YEARS.
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Grace L. Carrington M.D.
29c. License number: P12375
29d. Date signed (Month, Day, Year): JANUARY 14, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GRACE L. CARRINGTON 22 SOUTH GREENE STREET ROOM 5209 BALTO, MD 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Do Not Copy

Georgie Will
Do Replacement

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06251

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael Kestner
2. Date of Death (Month, Day, Year): February 27, 1999
3. Time of Death: 4:15 am
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice Care Program
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 301-54-5523
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 45 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEP 18, 1953
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 817 St. Paul Street #604
10f. Zip Code: 21202
10g. Citizen of What Country?: USA
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Retail
17. Father's Name (First, Middle, Last): George D. Kestner
18. Mother's Name (First, Middle, Maiden Surname): Dorothy M. Tabor
19a. Informant's Name/Relationship (Type, Print): Woodie Barnes/Lifetime Partner
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 817 St. Paul St. #604 Baltimore, MD 21202
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Cremtory, Inc.
Date: 2/27/99
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. AIDS — Unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Stella Maris at Mercy Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Darlene Robinson, MD

29c. License number: AU417643589322

29d. Date signed (Month, Day, Year): February 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Darlene Robinson, MD Greene Street, University of Maryland Medical Center

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999

32. Registrar's Signature: Irene G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Kestner, Michael

2 pgs

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 10f Per AB FilmG769 3-2-99 rja

Certificate of Death

Reg. No. 99 06252

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Aimee M. Kohn
2. Date of Death (Month, Day, Year): February 15, 1999
3. Time of Death: 9:40 PM
4a. Facility Name (If not institution, give street and number): Charlestown Care Center
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 135-03-4358
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 24, 1915
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 709 Maiden Choice Lane
10f. Zip Code: ~~21229~~ 21228
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Hospital
17. Father's Name (First, Middle, Last): Walter Lester Oswald
18. Mother's Name (First, Middle, Maiden Surname): Lola M. Smith
19a. Informant's Name/Relationship (Type, Print): Andrea Goldstein/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 109 Beechdale Road, Baltimore, Maryland 21210
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) — Date
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA — Approximate Interval Between Onset and Death: 1 WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Matthew J. Narrett
29c. License number: D44748
29d. Date signed (Month, Day, Year): February 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MATTHEW J. NARRETT 711 MAIDEN CHOICE LANE CATONSVILLE, MD 21228

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Donna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06253

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Virginia Lotz
2. Date of Death (Month, Day, Year): February 28, 1999
3. Time of Death: 6:00 A.M.
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 213-74-0768
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 2, 1906
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll County
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1310 Woodridge Lane
10f. Zip Code: 21784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Walter Wesley Marks
18. Mother's Name (First, Middle, Maiden Surname): Elsie Horan
19a. Informant's Name/Relationship (Type, Print): Donald Lotz (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1310 Woodridge Lane, Sykesville, Maryland 21784
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: MAR. 2
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, Maryland 21133

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Dementia — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): February 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto MD 21204

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Mildred Lotz February 28, 1999 6:00am

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Penna B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06254

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth S. Law
2. Date of Death (Month, Day, Year): Feb 27 1999
3. Time of Death: 11⁴⁵ A.M.
4a. Facility Name (If not institution, give street and number): 3302 Springdale Ave.
4b. City, Town, or Location of Death: Balto.
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-10-7483
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): April 30, 1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Balto.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3302 Springdale Ave.
10f. Zip Code: 21218
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 8
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): William Smith
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Dunivile

19a. Informant's Name/Relationship (Type, Print): Mildred Fowlkes-St. Cyr
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1501 Northgate Rd. Balto. Md. 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park | Date: 3-6-99
20c. Location - City or Town, State: Balto. Md. 21217

21. Signature of Funeral Service Licensee: ▶ Carlton C. Douglass
22. Name and Address of Facility: Douglass Funeral Service, 1701 McCulloh St. Balto. Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Probable Myocardial Infarction

Due to (or as a consequence of):

b. Arteriosclerotic Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Previous Stroke
Previous intestinal bleeding
Diverticulosis, Arthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Rifat Abousy MD
29c. License number: D12729
29d. Date signed (Month, Day, Year): 3/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rifat Abousy MD 2300 Garrison Blvd

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20 pgs

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06255

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY T. LANE
2. Date of Death: Month FEBRUARY Day 26 Year 1999
3. Time of Death: 10:52 AM
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 217-18-0058
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-23-25
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [ ] No XX
10e. Street and Number: 5220 York Road Apt.#3-K
10f. Zip Code: 21212
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: various trades
17. Father's Name (First, Middle, Last): Jarvis Lane
18. Mother's Name (First, Middle, Maiden Surname): Pauline Thomas
19a. Informant's Name/Relationship (Type, Print): Helen Lane
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212: 5220 York Road Apt.#3-K Baltimore, MD.
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville VA Cem.
Date: 03-03-99
20c. Location - City or Town, State: Crownsville, MD
21. Signature of Funeral Service Licensee: Bernard D Johnson
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. EMPHYSEMA — Approximate Interval Between Onset and Death: YEARS

Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — YEARS

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE
RECENT MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D15135
29d. Date signed (Month, Day, Year): FEBRUARY 26, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RENELUNE P. SCOTT MD 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Item#20b perFH G769 3/2/99 EW

Certificate of Death

Reg. No. 99 06256

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEON LASSMAN
2. Date of Death (Month, Day, Year): FEBRUARY 23, 1999
3. Time of Death: 8:17 AM
4a. Facility Name (If not institution, give street and number): JEWISH CONVALESCENT CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 154-14-2471
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR. 15, 1916
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: LUTHERVILLE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 300 W. SEMINARY AVE. - APT. 222
10f. Zip Code: 21093
10g. Citizen of What Country? U.S.A.

11. Merital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ARTIST
16b. Kind of Business/Industry: ART

17. Father's Name (First, Middle, Last): (UNKNOWN) LASSMAN
18. Mother's Name (First, Middle, Maiden Surname): (UNKNOWN)

19e. Informant's Neme/Reletionship (Type, Print): LOUIS J. WEINKAM, JR. / ATTORNEY
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1002 FREDERICK ROAD - CATONSVILLE, MD 21228

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Anshe Emunah- Aitz Chaim ~~NEW HAR SINAI CEMETERY~~ Dete: 2/ 25/99
20c. Location - City or Town, Stete: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: Scott M. Cuttle
22. Neme end Address of Fecility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not entar the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on each lina.

		Approximeta Intervel Between Onset and Death
Immediata Cause (Finel disease or condition resulting in death)	a. Cerebral thrombosis	>1 year
	Due to (or as a consequence of):	
Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. atherosclerotic cardiovascular disease	>5 years
	Due to (or as a consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes casa referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Ptece of Death (Check only ona): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): N/A
28b. Time of Injury: M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and mennar as stated. 2 ☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the tima, date end place, and due to the cause(s) and manner stated.

29b. Signeture and title of Certifier: David Bohn
29c. License number: D15872
29d. Data signed (Month, Day, Year): February 23 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harold Bod 25 Main St 21136 Reisterstown

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

8

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06257

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Reb Lichtfuss
2. Date of Death (Month, Day, Year): February 24, 1999
3. Time of Death: 6:45am
4a. Facility Name (If not institution, give street and number): Augsburg Lutheran Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-03-5988
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 22, 1907
9. Birthplace (State or Foreign Country): Romania

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6811 Campfield Road
10f. Zip Code: 21207
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeping Supervisor
16b. Kind of Business/Industry: Hospital
17. Father's Name (First, Middle, Last): Anthony Reb
18. Mother's Name (First, Middle, Maiden Surname): Rosalia Hajeck
19a. Informant's Name/Relationship (Type, Print): John Lichtfuss, Jr. (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8800 Walther Blvd. Apt 1406, Baltimore, MD 21234
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park | Date: 3/1/99
20c. Location - City or Town, State: Glen Burnie, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. pneumonia — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

UTI

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D37573
29d. Date signed (Month, Day, Year): Feb 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeff Tibell MD 7220 Park Heights Ave Baltimore MD 21208

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06258

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Leopold LeMay
2. Date of Death (Month Day Year): MARCH 1, 1999
3. Time of Death: 4:15 AM
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-03-2801
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01/18/1912
9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3005 Woodside Avenue
10f. Zip Code: 21234
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Body & Fender
16b. Kind of Business/Industry: Automotive

17. Father's Name (First, Middle, Last): Alberic LeMay
18. Mother's Name (First, Middle, Maiden Surname): Caroline Fournier

19a. Informant's Name/Relationship (Type, Print): Catherine M. LeMay
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3005 Woodside Avenue Baltimore, Maryland 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 3/2/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — 2 DAYS
Due to (or as a consequence of):
b. ACUTE RENAL FAILURE — 2 DAYS
Due to (or as a consequence of):
c. ACUTE ABDOMEN — 2 DAYS
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joginder P Mehta M.D.
29c. License number: D 41410
29d. Date signed (Month, Day, Year): March 1st, 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: [signature]

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06259

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William McFadden
2. Date of Death: Month February, Day 26, Year 1999
3. Time of Death: 1409

4a. Facility Name (If not institution, give street and number): University of Maryland Medical System
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 245-54-1882
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 2 1929
9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1329 N. Carey St.
10f. Zip Code: 21217
10g. Citizen of What Country? USA

To Be Completed by Funeral Director

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4th | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Welder
16b. Kind of Business/Industry: Galvanized Steel
17. Father's Name (First, Middle, Last): William A. McFadden I
18. Mother's Name (First, Middle, Maiden Surname): Fannie Mae Frison
19a. Informant's Name/Relationship (Type, Print): Linda Drake-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3127 Cresson Ave. Balto. Md 21244
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cem.
Date: 3/5/99
20c. Location - City or Town, State: Glen Burnie Md
21. Signature of Funeral Service Licensee: Glenna B. Harris
22. Name and Address of Facility: March Funeral Home West, Inc. 4300 Wabash Ave. Balto. Md. 21215

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration	4 hours
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Cerebrovascular Accident	9 days
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Shelley L. Rudgrass MD
29c. License number: P12492
29d. Date signed (Month, Day, Year): February 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): University of Maryland 22 South Greene Street Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Geneva B. Sparks

2
RED

DHMH 16 Rev 6/95

99-0944-033
crn
Rita Dorothy Miller

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06260

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Rita D. Miller
2. Date of Death (Month, Day, Year): February 16, 1999
3. Time of Death: 7:00 P.M.
4e. Facility Name (If not institution, give street and number): 9000 Briarcroft Dr., #341
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's
5. Social Security Number: 200-20-8072
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 28, 1927
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 9000 Briarcroft Lane, #341
10f. Zip Code: 20708
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): Ø
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Michael Calgelia
18. Mother's Name (First, Middle, Maiden Surname): Philamina Priora
19e. Informant's Name/Relationship (Type, Print): Tom Markland/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9370 Breamore Court, Laurel, Maryland 20723
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Union Cemetery — Date: 2/24/99
20c. Location - City or Town, State: Burtonsville, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Rd., Laurel, Maryland 20707

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease — Approximate Interval Between Onset and Death

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chute
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): February 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06261

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL MECHLOVICS
2. Date of Death (Month, Day, Year): FEBRUARY 26, 1999
3. Time of Death: 9:00 AM
4a. Facility Name (If not institution, give street and number): LEVINDALE HEBREW HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-30-7279
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 10, 1912
9. Birthplace (State or Foreign Country): HUNGARY

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2500 W. BELVEDERE AVE. #1112
10f. Zip Code: 21215
10g. Citizen of What Country?: HUNGARY

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BAKER
16b. Kind of Business/Industry: CULINARY ARTS

17. Father's Name (First, Middle, Last): WOLFE HIRSCH
18. Mother's Name (First, Middle, Maiden Surname): UNOBTAINABLE

19a. Informant's Name/Relationship (Type, Print): DR. DAVID ZISOW / NEPHEW
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 MARCIE WOODS COURT - BALTIMORE, MD 21208

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH TFILOH CEMETERY
Date: 2/28/99
20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Right Cerebrovascular Accident — Approximate Interval Between Onset and Death: 24h

Due to (or as a consequence of):
b. Atherosclerotic Cardiovascular Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Hypertension — years

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
GERD, Esophageal strictures, dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D33943
29d. Date signed (Month, Day, Year): 2/26/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Levindale

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature]

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial-transit place.

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06262

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Norma Louise Middleton
2. Date of Death (Month Day Year): March 1, 1999
3. Time of Death: 5:30am
4a. Facility Name *(If not institution, give street and number)*: Crofton Conv. Center
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 493-32-6509
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 30, 1910
9. Birthplace *(State or Foreign Country)*: Missouri

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Crofton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1664 Walleye Drive
10f. Zip Code: 21114
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cashier
16b. Kind of Business/Industry: Convenience Store
17. Father's Name *(First, Middle, Last)*: Frederick Hampton
18. Mother's Name *(First, Middle, Maiden Surname)*: Myrtle Sedgwick
19a. Informant's Name/Relationship *(Type, Print)*: Richard A. Middleton, Sr. -Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1664 Walleye Drive, Crofton, MD 21114
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory — Date: 3/2
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Kimberly S Rose
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. myocardial infarction — Approximate Interval Between Onset and Death: none

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus, type II
Polymyalgia Rheumatica
morbid obesity

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Obery MD
29c. License number: D 00 295 71
29d. Date signed *(Month, Day, Year)*: 3/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Paul Berez 1655 Crofton Blvd suite 101 Crofton MD 21114

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 - 1999
32. Registrar's Signature: Laura B. Sparks

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ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06263

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Wood Many
2. Date of Death (Month, Day, Year): February 10, 1999
3. Time of Death: 10:30 A.M.
4a. Facility Name (If not institution, give street and number): 10511 Lester Street
4b. City, Town, or Location of Death: Wheaton
4c. County of Death: Montgomery County

Funeral Director

5. Social Security Number: 225-72-8144
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 22, 1905
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Virginia
10b. County: Rappahannock
10c. City, Town or Location: Sperryville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 94 Many Lane
10f. Zip Code: 22740
10g. Citizen of What Country? United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Thomas Wood
18. Mother's Name (First, Middle, Maiden Surname): Daisy Sealock
19a. Informant's Name/Relationship (Type, Print): Sue Deal / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13385 Chesterfield Lane, Culpeper, Virginia 22701
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sperryville Cemetery
Date: February 13, 1999
20c. Location - City or Town, State: Sperryville, Virginia
21. Signature of Funeral Service Licensee: ▶ Allen W. Doe
22. Name and Address of Facility: Clore-Geest Funeral Home (11190 James Monroe Hwy) P.O. Box 100, Culpeper, Virginia

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident — 2 mos.
Due to (or as a consequence of):
b. Arteriosclerotic Cardio-vascular — 10 yrs
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Daughter's Residence
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶
29c. License number: D41931
29d. Date signed (Month, Day, Year): Feb. 23, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ronald J. Shumacher, M.D. 2309 Shorefield Road, Wheaton, Maryland 20902

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06264

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DIANE MCHALE
2. Date of Death (Month, Day, Year): FEB 28 1999
3. Time of Death: 0750 AM
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 078-34-9733
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 10,1943
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11165 Oaken Shield Circle
10f. Zip Code: 21044
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Real Estate Agent
16b. Kind of Business/Industry: O;Conor, Piper & Flynn

17. Father's Name (First, Middle, Last): Edward Smolka
18. Mother's Name (First, Middle, Maiden Surname): Viola Kudla

19e. Informant's Name/Relationship (Type, Print): John McHale (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11165 Oaken Shield Circle, Columbia, MD 21044

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crestlawn Cemetery
Date: 3/4/99
20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, MD 21045

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA — 12 HOURS
Due to (or as a consequence of):
b. ENCEPHALOPATHY — 3 MONTHS
Due to (or as a consequence of):
c. PRIOR CEREBRAL INFARCTION — 12 MONTHS
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D 29909
29d. Date signed (Month, Day, Year): FEB 28 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SCOTT MAURER 9501 OLD ANNAPOLIS RD ELLICOTT CITY MD 21042

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06265

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vernon Edgar MacCumbee, Sr.
2. Date of Death (Month, Day, Year): February 19 1999
3. Time of Death: 2215
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 234-24-4143
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 23, 1913
9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 22143 Ringgold Pike
10f. Zip Code: 21742
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tool Expediter
16b. Kind of Business/Industry: Aircraft Manufacture

17. Father's Name (First, Middle, Last): John Thomas MacCumbee
18. Mother's Name (First, Middle, Maiden Surname): Cecilia Potter

19a. Informant's Name/Relationship (Type, Print): Lois L. MacCumbee/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22143 Ringgold Pike Hagerstown, MD 21742

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Peter's Catholic — Date: 2/23/99
20c. Location - City or Town, State: Hancock, MD 21750

21. Signature of Funeral Service Licensee: Richard [signature]
22. Name and Address of Facility: Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750-0368

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. DILATED CARDIOMYOPATHY — 5 years
Due to (or as a consequence of):
b. AORTIC INSUFFICIENCY — 5 years
Due to (or as a consequence of):
c. CALCIFIC AORTIC STENOSIS — 5 years
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PANCREATITIS
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D43590
29d. Date signed (Month, Day, Year): 2/22/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John P. Ulrich 22911 Jefferson Blvd Smithsburg MD 21783

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

RKD
99-1088-510
MARY ANN
MATTHEWS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06266

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Ann Matthews
2. Date of Death (Month, Day, Year): FEBRUARY 24, 1999
3. Time of Death: 4:36P.M.
4a. Facility Name (If not institution, give street and number): 524 N.CHARLES STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-14-8260
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB 17, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 524 N. Charles Street
10f. Zip Code: 21201
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Bakery

17. Father's Name (First, Middle, Last): Vaughn Matthews, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Irene Seibel

19a. Informant's Name/Relationship (Type, Print): Vaughn Matthews, Jr./Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1328 Washington Blvd. Baltimore, MD 21230

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: 2/26/99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? INSPECTION 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Pestaner, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): FEBRUARY 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5
P.23

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06267

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Townshend Ripley Martin
2. Date of Death (Month, Day, Year): FEB 24, 1999
3. Time of Death: 11:30 AM
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 220-30-5870
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 15, 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Davidsonville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3019 Davidsonville Road
10f. Zip Code: 21035
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Farming

17. Father's Name (First, Middle, Last): Charles B. Townshend
18. Mother's Name (First, Middle, Maiden Sumeme): Rosa Mae Waters

19a. Informant's Neme/Relationship (Type, Print): Charles T. Ripley/Son
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3019 Davidsonville Road Davidsonville, MD 21035

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Metro Crematory, Inc. | Date: 3/1/99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Edward A. Gregorchik
22. Name and Address of Fecility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Immediate Cause (Finet disease or condition resulting in death): a. Lung Cancer — Approximete Interval Between Onset end Death: 9 months

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Chronic Obstructive Pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ Wayne D. Bierbaum, MD
29c. License number: D38563
29d. Date signed (Month, Day, Year): February 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wayne D. Bierbaum 134 Owensville Rd West River MD

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06268

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Audrey T. McCormick
2. Date of Death (Month Day Year): March 1, 1999
3. Time of Death: 1:45 AM
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-01-9952
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC 2, 1904
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2300 Dulaney Valley Road
10f. Zip Code: 21093
10g. Citizen of What Country?: USA
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Roofing
17. Father's Name (First, Middle, Last): William Thrasher
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Gallagher
19a. Informant's Name/Relationship (Type, Print): Marguerite L. Heuman / cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1718 Rollins Ct. Bel Air, MD 21014
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. — Date: 03/02/99
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: George E. MacNabb
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mark R Stoms MD
29c. License number: D32543
29d. Date signed (Month, Day, Year): March 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARK STHOMSON MD 6701 N. Charles St. Baltimore MD

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 7 per F.H G-769 3/2/99 reb

Certificate of Death

Reg. No. 99 06269

AKA: MENDELL, RAYMOND L.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner — **Funeral Director** — To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Raymond Leroy Mendell, Jr.
2. Date of Death: Month Feb, Day 24, Year 1999
3. Time of Death: 5:10 A.M.
4a. Facility Name (If not institution, give street and number): VA MEDICAL CENTER
4b. City, Town, or Location of Death: FORT HOWARD
4c. County of Death: BALTIMORE
5. Social Security Number: 216-24-5237
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): ~~70~~ 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC 17, 1929
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 5435 Hilltop Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: USA
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1947-67
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Guard
16b. Kind of Business/Industry: Security
17. Father's Name (First, Middle, Last): Raymond Leroy Mendell, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Anna Mack
19a. Informant's Name/Relationship (Type, Print): Nga Mendell/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5435 Hilltop Avenue Baltimore, MD 21206
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: 2/26/99
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner — Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Carcinoma of Larynx	4 years
Due to (or as a consequence of):	b. Metastatic Carcinoma of Head and Neck	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. Metastatic Abdominal Mass	months
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Augustin Chyu M.D.
29c. License number: D-18298
29d. Date signed (Month, Day, Year): Feb. 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Augustin Chyu, M.D., VA MEDICAL CENTER, FT. HOWARD, MD 21052

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: Irene G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06270

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES MAJORS
2. Date of Death: Month 02 Day 17 Year 99
3. Time of Death: 03.20
4a. Facility Name (If not institution, give street and number): Church Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 215-80-6302
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 39 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 25, 1959
9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2520 E. Eager Street
10f. Zip Code: 21205
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? unknown 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Cora Majors/sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2520 E. Eager Street, Baltimore, Maryland 21205

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place): Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

NAME KNOWN TO PHYSICIAN

permit. Pages 1 and 2 must be filed within 24 hours and returned to the Department of Health and Mental Hygiene within 72 hours after death. Important: If Item 27 is marked "Pending Investigation" or "Could not be determined" or if a medical examiner has taken any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPTIC SHOCK — 24 hrs

Due to (or as a consequence of):
b. PNEUMONIA — 72 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ACQUIRE IMMUNE DEFICIENCY SYNDROME

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: R Skulski M.D.
29c. License number: D00 53296
29d. Date signed (Month, Day, Year): 02.17.99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. SKULSKI, M.D. CHURCH HOME and HOSPITAL, BALTIMORE, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Geneva G. Brooks

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ORIGINAL

NAME KNOWN TO PHYSICIAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06271

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy F. Myers
2. Date of Death (Month, Day, Year): February 21, 1999
3. Time of Death: 5:00 AM
4a. Facility Name (If not institution, give street and number): Future Care Nursing Home
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 260-44-7367
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 16, 1905
9. Birthplace (State or Foreign Country): Indiana

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Arnold
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 305 College Parkway
10f. Zip Code: 21012
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 04
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: School
17. Father's Name (First, Middle, Last): Theodore Finley
18. Mother's Name (First, Middle, Maiden Surname): Katheryn Ayers
19a. Informant's Name/Relationship (Type, Print): Lisa K. Petersen/granddaughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 703 Pin Oak Road, Severna Park, Maryland 21146
20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. respiratory failure — hours

Due to (or as a consequence of):
b. pneumonia — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
prior methicillin resistant staph aureus pneumonia, cerebrovascular accident, dysphagia, gastrostomy

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D41955
29d. Date signed (Month, Day, Year): 2-23-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rebecca Elon MD 1454 B+A Blvd Arnold MD 21012

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Bevin G. Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

To be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06272

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Elizabeth Oliver
2. Date of Death (Month, Day, Year): Feb. 19, 1999
3. Time of Death: 7:00A.M.
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 230-68-0383
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 17, 1914
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Va.
10b. County: Gloucester
10c. City, Town or Location: Ark
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5695 Hickory Hill Lane
10f. Zip Code: 23003
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home
17. Father's Name (First, Middle, Last): Walter Lee Trevillian
18. Mother's Name (First, Middle, Maiden Surname): Mary Alice Rilee
19a. Informant's Name/Relationship (Type, Print): Mary Lee Darling / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 943, Williamsburg, Va. 23187
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bellamy Un. Meth. Church
Date: 2-22-99
20c. Location - City or Town, State: Glou.Co., Va.
21. Signature of Funeral Service Licensee: ▶ Thomas J. Hardesty
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure

Due to (or as a consequence of):
b. Pulmonary Edema

Due to (or as a consequence of):
c. Pneumonia

Due to (or as a consequence of):
d. Hypoalbuminemia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [illegible] M.D.
29c. License number: D0051437
29d. Date signed (Month, Day, Year): 2/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): OKEDWO DARCY IBITOYE ANNE ARUNDEL MED. CTR ANAPOLIS MD.

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ [illegible] B. Sparks

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06273

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louise S. O'Neill
2. Date of Death: Month Feb Day 28 Year 1999
3. Time of Death: 13.30 pm
4a. Facility Name (If not institution, give street and number): St Agnes Health Care
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 219-03-4044
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 28,1919
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 402 Locust Drive
10f. Zip Code: 21228
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 12 — College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Louis Starr
18. Mother's Name (First, Middle, Maiden Surname): Anne Bauer
19a. Informant's Name/Relationship (Type, Print): John W. O'Neill (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 402 Locust Drive, Catonsville, MD 21228
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park — Date: 3/3/99
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Robert [illegible] Bu[illegible]
22. Name and Address of Facility: Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration pneumonia	10 days
Due to (or as a consequence of):	b. COPD	15 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Urinary tract infection	10 days
Due to (or as a consequence of):	d. Alzheimer Dementia	3 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] M.D.
29c. License number: P 12595
29d. Date signed (Month, Day, Year): Feb / 28 / 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mustapha Mallah. St Agnes Health Care 900 Caton Avenue Baltimore MD 21229

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: [illegible] G. Sparks

DHMH 16 Rev 6/95

ONEILL LOUISE

6 Rec

99-0920-510
crn
Unknown 99-037
KEVIN PHILLIP PAYNE ITEMS: #23 PART I, 27, 28A-F PER MEO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

G769 3-8-99 WR.

Certificate of Death

Reg. No. 99 06274

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kevin Payne
2. Date of Death (Month, Day, Year): February 18, 1999
3. Time of Death: 7:59 A.M.
4a. Facility Name (If not institution, give street and number): Alley between 828 & 830 North Carey Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-04-6226
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 31 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 20, 1967
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 835 N. Fulton Ave. 3rd Floor
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COOK
16b. Kind of Business/Industry: Bertucci's Restaurant

17. Father's Name (First, Middle, Last): Joseph Blanding
18. Mother's Name (First, Middle, Maiden Surname): Sylvia Brown

19a. Informant's Name/Relationship (Type, Print): Ira Payne - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 835 N. Fulton Ave. 3rd Floor Balto, MD. 21217

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 2/3
20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: Kevin Parker
22. Name and Address of Facility: Kevin A. Parker Funeral Home 3512 Frederick Ave. Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined

28a. Date of Injury (Month, Day, Year): Found: 2-18-99
28b. Time of Injury: Found: 7:30 A M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND: ALLEY
28f. Location (Street and Number or Rural Route Number, City or Town, State): 828 & 830 N. CAREY ST. BALTIMORE, MARYLAND

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Maryann Melkvile
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): February 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANNA A. KOWAL MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: Gina G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06275

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Robert Phillips
2. Date of Death: Month February Day 27 Year 1999
3. Time of Death: 11:35A
4a. Facility Name (If not institution, give street and number): Fallston General Hospital
4b. City, Town, or Location of Death: Fallston
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 467-01-7397
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. If Under 1 Year: Months Days; If Under 24 Hrs.: Hours Min.
8. Date of Birth (Month, Day, Year): Dec. 7, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9820 Fox Hill Road
10f. Zip Code: 21128
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Design Engineer
16b. Kind of Business/Industry: Manufacturing
17. Father's Name (First, Middle, Last): Crystal Parker Phillips
18. Mother's Name (First, Middle, Maiden Surname): Matilda Adelman
19a. Informant's Name/Relationship (Type, Print): Mrs. Ruth E. Phillips (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9820 Fox Hill Rd., Perry Hall, MD 21128
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem.
Date: 3/2/99
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: ▶ Robert Wadach
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. stroke, acute — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Extensive, bilateral old ischemic infarcts, years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary viral infection, Dehydrated state.

23b. **Did tobacco use contribute to the cause of death?** 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Albert S.C. Sun, M.D.
29c. License number: D18779
29d. Date signed (Month, Day, Year): February 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Albert S.C. SUN, M.D. 1800 Harford Road, Fallston, MD 21047

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Phillips, James

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: ▶

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06276

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nannie Pruitt
2. Date of Death (Month, Day, Year): February 27, 1999
3. Time of Death: 4:30 AM
4a. Facility Name (If not institution, give street and number): Riverview Care Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 228-10-9704
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 27, 1910
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4910 E. Federal Street
10f. Zip Code: 21205
10g. Citizen of What Country?: U. S. A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dietician
16b. Kind of Business/Industry: Baltimore City
17. Father's Name (First, Middle, Last): Edward Parks
18. Mother's Name (First, Middle, Maiden Surname): Edith Parks
19a. Informant's Name/Relationship (Type, Print): Robert Lee Pruitt (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4910 E. Federal Street, Baltimore, Maryland 21205
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park — Date: 3/1/99
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: ▶ Brian A. Willem
22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Dementia — Approximate Interval Between Onset and Death: 4 years.
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypothyroidism.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Michael Schwartz MD
29c. License number: D19667
29d. Date signed (Month, Day, Year): 3-1-99.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DOCTOR MICHAEL SCHWARTZ 5517 "A" RITCHIE HIGHWAY BALTIMORE MARYLAND 21225

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 0 2
32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06277

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John James Piccinetti, JR
2. Date of Death (Month, Day, Year): FEBRUARY 22, 1999
3. Time of Death: 0828
4a. Facility Name (If not institution, give street and number): LAUREL REGIONAL HOSPITAL
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 138-42-9284
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 50 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 30, 1948
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9438 A Merryrest Road
10f. Zip Code: 21045
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver
16b. Kind of Business/Industry: ITSI Towel

17. Father's Name (First, Middle, Last): John J. Piccinetti
18. Mother's Name (First, Middle, Maiden Surname): Shirley Link

19a. Informant's Name/Relationship (Type, Print): Shirley Krulikowski/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 Lamont Ave. Apt. 1003 Trenton, NJ 08619

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BGWCD Veteran's Mem. Cem.
Date: 3/01/99
20c. Location - City or Town, State: Rightstown, New Jersey

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER

CHRONIC ETHANOL ABUSE

CHRONIC SMOKING

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] DME
29c. License number: D33954
29d. Date signed (Month, Day, Year): FEBRUARY 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature]

10+1

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06278

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ralph Benson Plympton
2. Date of Death (Month, Day, Year): February 28, 1999
3. Time of Death: 7:40 am
4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 554-01-1424
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 15, 1916
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Deale
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5981 Deale Beach Road
10f. Zip Code: 20751
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician
16b. Kind of Business/Industry: Electrical

17. Father's Name *(First, Middle, Last)*: Ralph A. Plympton
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Jane Hess

19a. Informant's Name/Relationship *(Type, Print)*: Joyce Cramer - Neighbor
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5977 Deale Beach Road, Deale, MD 20751

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lakemont Memorial Gardens — Date: 03/05
20c. Location - City or Town, State: Davidsonville, MD

21. Signature of Funeral Service Licensee: Thomas O Hardesty
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MSL Physician
29c. License number: D47518
29d. Date signed *(Month, Day, Year)*: 2-28-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Therese Buck AAMC Franklin Cathedral St Annapolis MD 21401.

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 - 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06279

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Pope
2. Date of Death (Month, Day, Year): February 25, 1999
3. Time of Death: 1:10p.m.
4a. Facility Name (If not institution, give street and number): Millenium Nursing Home /Liberty Heights
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 212-32-3502
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 16, 1916
9. Birthplace (State or Foreign Country): Va.

Usual Residence of Decedent

10a. State: MD.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2121 Windsor Garden Lane
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: Private Families

17. Father's Name (First, Middle, Last): William UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): Mary Bland

19a. Informant's Name/Relationship (Type, Print): Margaret B. Medley niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11720 Luther Avenue South Seattle, Wash. 98178

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park — Date: March 6
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Coronary artery disease
Due to (or as a consequence of):
b. Craniopharyngeal dysphagia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D30115
29d. Date signed (Month, Day, Year): 2/26/99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T. Ohiokpehai, MD 2600 Liberty Hgts Ave. Baltimore MD 21215

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06280

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEON PLATER
2. Date of Death: Month FEBRUARY Day 25 Year 1999
3. Time of Death: 10:55a
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 213-34-5202
6. Sex: XX 1 ☐ M 2 ☐ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 23, 1936
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: XX 1 Yes 2 ☐ No
10e. Street and Number: 5101 Levindale Road
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elemantary/Secondary (0-12) | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Johns Hopkins Hospital
17. Father's Name (First, Middle, Last): Benjamin Plater
18. Mother's Name (First, Middle, Maiden Surname): Essie Elsey
19a. Informant's Name/Relationship (Type, Print): Carileen G. Plater wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5101 Levindale Road Baltimore, Md. 21215
20a. Method of Disposition: 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: March 1
20c. Location - City or Town, State: Baltimore, Md.
21. Signature of Funeral Service Licensee: ▶ Herbert E. Nutter
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HYPOVOLEMIC SHOCK — 12 hours
Due to (or as a consequence of):
b. ACIDOSIS — 1 day
Due to (or as a consequence of):
c. PRESUMED SEPSIS — 1 day
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pulmonary embolism, coronary artery disease, diabetes

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XX No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 XX No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 XX No
26. Place of Death (Check only one): Hospital: 1 XX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Holly R Dahlman MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): 2-25-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Holly R Dahlman, MD; Tower 116, 600 N WOLFE ST; BALTIMORE, MD 21287

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06281

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NELL J. PETERS
2. Date of Death (Month, Day, Year): FEB. 27 1999
3. Time of Death: 1:45 A.M.
4a. Facility Name (If not institution, give street and number): PERRING PARKWAY CENTER
4b. City, Town, or Location of Death: PARKVILLE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 232-22-3561
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR. 16, 1907
9. Birthplace (State or Foreign Country): W. VA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 6105 MOYER AVE.
10f. Zip Code: 21206
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE — College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PIANIST
16b. Kind of Business/Industry: RECREATION DEPT.
17. Father's Name (First, Middle, Last): JOSEPH CARRICO
18. Mother's Name (First, Middle, Maiden Surname): GRACE SKINNER
19a. Informant's Name/Relationship (Type, Print): NORMA BARRETT DAUGHTER-IN LAW
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2905 ANDORRA CT. APT. A BALTIMORE, MD 21234
20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARDENS OF FAITH CEMETERY
Date: 3/3/99
20c. Location - City or Town, State: ROSEDALE, MARYLAND
21. Signature of Funeral Service Licensee: ▶ Robert E. Altenburg, D00002
22. Name and Address of Facility: 6009 HARFORD ROAD ALTENBURG FUNERAL HOME, P.A. BALTIMORE MD 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ziad Mirza MD
29c. License number: D41901
29d. Date signed (Month, Day, Year): 3/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3007 E. Northern Parkway Balto. Md. 21214 Ziad Mirza, M.D.

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: ▶ G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06282

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sylvester Mahlon Queen
2. Date of Death: Month February Day 28th Year 1999
3. Time of Death: 2:45pm
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-22-8585
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR 25 1928
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: A.A.CO
10c. City, Town or Location: SEVERN
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 585 QUEENSTOWN ROAD
10f. Zip Code: 21144
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates: 52/54
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FT. MEADE
16b. Kind of Business/Industry: GOVERNMENT

17. Father's Name (First, Middle, Last): MAHLON QUEEN
18. Mother's Name (First, Middle, Maiden Surname): OTELIA MILIS

19a. Informant's Name/Relationship (Type, Print): Travis Queen/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 585 Queenstown Rd, Severn Md 21144

20a. Method of Disposition: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CROWNSVILLE VETERANS
Date: 3-5-99
20c. Location - City or Town, State: CROWNSVILLE, MARYLAND

21. Signature of Funeral Service Licensee: Barbara A. Brown
22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME, 1206 W NORTH AVENUE PA

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Queen Sylvester

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Pulmonarary Metastasis
Due to (or as a consequence of):
c. Carcinoma Rectum
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: House Staff
29c. License number: D51596
29d. Date signed (Month, Day, Year): February 28th 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. Ambalavanar, North Arundel Hospital, 301, Hospital Drive, Glen Burnie, MD 21061

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06283

LAURA Rettman

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Laura Lee Rettman
2. Date of Death (Month, Day, Year): February 26, 1999
3. Time of Death: 2:15 AM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-20-3025
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 15, 1903
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3907 Dudley Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Thomas White
18. Mother's Name (First, Middle, Maiden Surname): Kate Eder

19a. Informant's Name/Relationship (Type, Print): Dolores Kerr (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3907 Dudley Avenue, Baltimore, Maryland 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer — Date: 3/1/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Bruce C. Wellen
22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — Approximate Interval Between Onset and Death: 14 Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Michael Picco MD
29c. License number: D0051356
29d. Date signed (Month, Day, Year): February 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR Michael Picco 9000 Franklin Square Drive Baltimore, Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): MAR 0 2
32. Registrar's Signature: ▶ B. Sparks

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06284

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNIE RAINEY
2. Date of Death (Month, Day, Year): February 24 1999
3. Time of Death: 17:45
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 218-26-5356
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-12-29
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ 1 Yes 2☐ No
10e. Street and Number: 2214 Cedley Street
10f. Zip Code: 21230
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th Grade | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress
16b. Kind of Business/Industry: Read's
17. Father's Name (First, Middle, Last): Charlie Brame
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Lewis
19a. Informant's Name/Relationship (Type, Print): Elder Brame
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21230: 2214 Cedley Street Baltimore, Maryland
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Mem. Gardens
Date: 03-03-99
20c. Location - City or Town, State: Dundalk, MD
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. LYMPHOMA — 3 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature], MD
29c. License number: D051616
29d. Date signed (Month, Day, Year): February 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 600 NORTH WOLFE, BALTIMORE, MARYLAND 21287

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

2
PCD

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06285

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARION A. ROBINSON
2. Date of Death (Month Day Year): 02-27-1999
3. Time of Death: 5:35 PM
4a. Facility Name (If not institution, give street and number): WESTMINSTER NURSING HOME
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 212-20-4635
6. Sex: 1☐ M XX F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 11-26-1922
9. Birthplace (State or Foreign Country): MICHIGAN

Usual Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: XX Yes 2☐ No
10e. Street and Number: 1234 WASHINGTON ROAD
10f. Zip Code: 21157
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married XX Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2 YEARS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMINISTRATOR
16b. Kind of Business/Industry: JOHNS HOPKINS HOSPITAL

17. Father's Name (First, Middle, Last): AARON H. ANDREWS
18. Mother's Name (First, Middle, Maiden Surname): MONA LOGAN

19a. Informant's Name/Relationship (Type, Print): WADE F. ROBINSON,JR.(SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): TWO LOST TRAIL,LAWRENCEVILLE,N.J.,08648

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): DRUID RIDGE CEMETERY | Date: 3-4
20c. Location - City or Town, State: PIKESVILLE, MD.

21. Signature of Funeral Service Licensee: R. H. Rutt
22. Name and Address of Facility: HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD,BALTIMORE,MARYLAND,21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Respiratory arrest due to	15 min
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	b. Parkinsons disease	5 yr
	Due to (or as a consequence of):	
	c. Pseudo bulbar Palsy	20 yr
	Due to (or as a consequence of):	
	d. recurrent mucous plugging COPD	1 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

Medical Certification: To Be Completed by Physician/Medical Examiner

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Middleton
29c. License number: D 25443
29d. Date signed (Month, Day, Year): 2-28-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 288 Poole Road Westminster, Md 21157

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: Jennie G. Sparks

6 REB

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06286

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bruce Smith
2. Date of Death (Month, Day, Year): February 25, 1999
3. Time of Death: 1312
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-80-3800
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 36 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 4, 1962
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 528 Winston Ave.
10f. Zip Code: 21212
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Afro-American
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Care Provider
16b. Kind of Business/Industry: Nursing
17. Father's Name (First, Middle, Last): Johnnie L. Smith
18. Mother's Name (First, Middle, Maiden Surname): Jestine Chalmers
19a. Informant's Name/Relationship (Type, Print): Ms. Precious Smith (sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1841 Presstman St. Balto. Md.
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion — Date: 3/4/99
20c. Location - City or Town, State: Lansdowne, Md.
21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home, 2222 W. North Ave. Balto. Md. 21216

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMOCOCCAL SEPSIS	1 DAY
Due to (or as a consequence of):	b. PNEUMOCOCCAL PNEUMONIA	2 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD
29c. License number: D 15135
29d. Date signed (Month, Day, Year): February 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PENELOPE P. SCOTT MD 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2 pgs

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [illegible] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06287

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY SELLMAN
2. Date of Death: Month 2 Day 25 Year 99
3. Time of Death: 9:50 AM
4a. Facility Name (If not institution, give street and number): 2107 Presbury Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 220-18-9118
6. Sex: 1 ☐ M 2 ☑ F
7. Age (In yrs. last birthday): 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8 22 26
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 2107 Presbury Street
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bar Maid
16b. Kind of Business/Industry: Casino

17. Father's Name (First, Middle, Last): Rudolph Butler
18. Mother's Name (First, Middle, Maiden Surname): Dorothy Hanson

19a. Informant's Name/Relationship (Type, Print): Norma Holly - Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2104 Orleans St. Balto. Md. 21231

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Western Cemetery
Date: 3-2-99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jeff Miller
22. Name and Address of Facility: Jeff Miller P.C. Funeral Home & Services, 1439 N. Broadway Balto. Md. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arrythmia

Due to (or as a consequence of):
b. arthrosclerotic cardiovascular disease

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was cases referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Afza Ahmed M.D
29c. License number: D39127
29d. Date signed (Month, Day, Year): 3/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. AHMED 821 N. Eutaw Street Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Geneva G.

3

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06288

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEONARD W. SOBCZAK SR.
2. Date of Death (Month, Day, Year): FEBRUARY 25 1999
3. Time of Death: 0830h
4a. Facility Name (If not institution, give street and number): Fallston General Hospital
4b. City, Town, or Location of Death: Fallston
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 212-05-9930
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 11, 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Port Deposit
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 63 Rosemont Farm Lane
10f. Zip Code: 21904
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tool and Die Maker
16b. Kind of Business/Industry: Steel Company
17. Father's Name (First, Middle, Last): Matthew Sobczak
18. Mother's Name (First, Middle, Maiden Surname): Anna Studzinski
19a. Informant's Name/Relationship (Type, Print): Patricia B. Barnes (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 63 Rosemont Farm Lane, Port Deposit, MD. 21904
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer Cem. — Date: 3/1/99
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. VENTRICULAR FIBRILLATION — Approximate Interval Between Onset and Death: 15 minutes
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE — SEVERAL YRS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

CANCER OF THE PROSTATE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D25027
29d. Date signed (Month, Day, Year): FEBRUARY 25 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIJAY M. ABHYANKAR 2 NORTH AVENUE BEL AIR MD 21014

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Leonard Sobczak

6+1 RCPS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06289

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RICHARD SZYMANSKI
2. Date of Death (Month, Day, Year): February 14, 1999
3. Time of Death: 10 AM
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 216-72-6022
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 39 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 30, 1959
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 7501 Iroquois Avenue
10f. Zip Code: 21219
10g. Citizen of What Country?: USA

11. Marital Status: [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): Ø
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Janitorial
16b. Kind of Business/Industry: Maintenance

17. Father's Name (First, Middle, Last): Richard E. Szymanski
18. Mother's Name (First, Middle, Maiden Surname): (Unavailable) Phillips

19a. Informant's Name/Relationship (Type, Print): M. P. Szymanski/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7501 Iraquois Avenue, Baltimore, Maryland 21219

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Washington Cr.
Date: 2/17/99
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE PANCREATITIS	3 DAYS
Due to (or as a consequence of):	b. ALCOHOLISM	MORE THAN FIVE DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RESTRICTIVE LUNG DISEASE, OBESITY
DIABETES MELLITUS, HYPERTENSION,
ALCOHOLIC HEPATITIS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: RESIDENT PHYSICIAN EAgborbesong MD
29c. License number: 97008
29d. Date signed (Month, Day, Year): FEBRUARY 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATIENCE AGBORBESONG 4940 EASTERN AVENUE, BALTIMORE MARYLAND 21224

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06290

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LILLIE SHER
2. Date of Death (Month, Day, Year): FEBRUARY 23, 1999
3. Time of Death: 7:40 PM
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-28-7908
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 15,1908
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7121 PARK HEIGHTS AVENUE #609
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: EDUCATION
17. Father's Name (First, Middle, Last): JACOB GOLDMAN
18. Mother's Name (First, Middle, Maiden Surname): ANNE POTTS
19a. Informant's Name/Relationship (Type, Print): DEBRA KROME / NIECE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3801 CANTERBURY ROAD - BALTIMORE, MD 21218 APT. 504
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HEBREW YOUNG MEN CEMETERY | Date: 2/25/99
20c. Location - City or Town, State: WOODLAWN, MD
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary edema
Due to (or as a consequence of):
b. Arterio-sclerotic heart disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Hassan [signature] M
29c. License number: D22530
29d. Date signed (Month, Day, Year): 2/24/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HASSAN MAKHZOUMI PROF. CTR 120 SISTER PIERRE DR. TOWSON, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

15

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06291

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IRENE SHIFREN
2. Date of Death (Month Day Year): FEBRUARY 26, 1999
3. Time of Death: 9:00 AM
4a. Facility Name (If not institution, give street and number): 6920 MARSUE DRIVE, APT. 1-C
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-68-0138
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 8, 1913
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes ☒ No
10e. Street and Number: 6920 MARSUE DRIVE, APT. 1-C
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME
17. Father's Name (First, Middle, Last): SAMUEL LEVY
18. Mother's Name (First, Middle, Maiden Surname): ELLA LIPMAN
19a. Informant's Name/Relationship (Type, Print): HARRY SHIFREN / HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6920 MARSUE DRIVE, APT. 1-C BALTIMORE, MD 21215
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARLINGTON CHIZUK AMUNO
Date: 2/28/99
20c. Location - City or Town, State: BALTIMORE, MD
21. Signature of Funeral Service Licensee: Robert Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. ASCVD — Approximate Interval Between Onset and Death: 10 years

Due to (or as a consequence of): b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Aortic valve disease
Peripheral vascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Samuel L. Berry, MD
29c. License number: D16941
29d. Date signed (Month, Day, Year): 2/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S BERRY 21 Crossroads Dr Owings Mills, Md 21117

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06292

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): MARGARET ELAINE SHOFER
2. Date of Death (Month, Day, Year): FEBRUARY 27, 1999
3. Time of Death: 17:05
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A
5. Social Security Number: 200-01-2600
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 13, 1914
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7111 PARK HEIGHTS AVENUE #612
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BUYER
16b. Kind of Business/Industry: RETAIL CLOTHING
17. Father's Name (First, Middle, Last): HOWARD McLAUGHLIN
18. Mother's Name (First, Middle, Maiden Surname): ELLEN ROWEN
19a. Informant's Name/Relationship (Type, Print): THOMAS SHOFER / HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7111 PARK HEIGHTS AVE. #612 - BALTIMORE, MD 21215
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH EL MEMORIAL PARK
Date: 3/1/99
20c. Location - City or Town, State: RANDALLSTOWN, MD
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PULMONARY EDEMA — 18 DAYS

Due to (or as a consequence of):

b. PNEUMONIA — 18 DAYS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

DIABETES

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature], MD
29c. License number: P12333
29d. Date signed (Month, Day, Year): FEBRUARY 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SINAI HOSPITAL OF BALTIMORE JOSEPHINE OWUSU-SAKYI, 2401 WEST BELVEDERE AVE, BALTIMORE MD 21215

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ELAINE SHOFER

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06293

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MAX SOLOMON
2. Date of Death (Month, Day, Year): FEBRUARY 25, 1999
3. Time of Death: 5 45 PM
4a. Facility Name *(If not institution, give street and number)*: NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-05-0519
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 9, 1917
9. Birthplace *(State or Foreign Country)*: MICHIGAN

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1309 ASBURY ROAD
10f. Zip Code: 21209
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALES
16b. Kind of Business/Industry: HOME IMPROVEMENT
17. Father's Name *(First, Middle, Last)*: MORRIS SOLOMON
18. Mother's Name *(First, Middle, Maiden Surname)*: MINNIE KRAUSE
19a. Informant's Name/Relationship *(Type, Print)*: HOWARD SOLOMON / SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1309 ASBURY ROAD - BALTIMORE, MD 21209
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MARYLAND VETERANS CEMETERY — Date: 3/1/99
20c. Location - City or Town, State: OWINGS MILLS, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — Approximate Interval Between Onset and Death: 15 DAYS

Due to (or as a consequence of): b. BILATERAL PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] C. Ravi MD
29c. License number: D 37333
29d. Date signed *(Month, Day, Year)*: FEBRUARY 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. RAVI MD, NHC, BALTO. MD 21133

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 - 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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State of Maryland / Department of Health and Mental Hygiene

ITEM: #10E PER F.H. F.H. G769 3-5-99 WR.

Certificate of Death

Reg. No. 99 06294

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Cecilia Simons
2. Date of Death (Month, Day, Year): February 26 1999
3. Time of Death: 5:25 am
4a. Facility Name (If not institution, give street and number): Larkin Chase Nursing Home
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 213-12-3980
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 21,1921
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12905 CLEARFIELD DRIVE ~~15005 Health Center Drive~~
10f. Zip Code: 20715
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Copy
17. Father's Name (First, Middle, Last): Svend Christian Helfer
18. Mother's Name (First, Middle, Maiden Surname): Mildred Catherine Pipher
19a. Informant's Name/Relationship (Type, Print): Howard Simons, Jr. -- Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12725 Millstream Drive, Bowie, MD 20715
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery — Date: 03/01/99
20c. Location - City or Town, State: Brentwood, MD
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Cirrhosis — 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Alcoholism

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Gastrointestinal Hemorrhage

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D50343
29d. Date signed (Month, Day, Year): February 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kelvin Hao MD 3231 Superior Lane Suite A-6 Bowie, Maryland 20715

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06295

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Israel Silber
2. Date of Death (Month, Day, Year): Feb 26 1999
3. Time of Death: 9 PM
4a. Facility Name *(If not institution, give street and number)*: Genesis Eldercare Spa Creek
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 089-05-0795
6. Sex: 1☐ M 2☐ F
7. Age *(In yrs. last birthday)*: 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 14, 1904
9. Birthplace *(State or Foreign Country)*: New York City

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 800 Bestgate Road
10f. Zip Code: 21401
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Linotype Operator
16b. Kind of Business/Industry: Printing
17. Father's Name *(First, Middle, Last)*: Isaac Silber
18. Mother's Name *(First, Middle, Maiden Surname)*: Rebecca Glanz
19a. Informant's Name/Relationship *(Type, Print)*: Irwin Silber/ Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 221 Cape St. John Road Annapolis, MD 21401
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: United Hebrew Cemetery | Date: 2-28-99
20c. Location - City or Town, State: Richmondtown New York Staten Island
21. Signature of Funeral Service Licensee: Thomas A Hardesty
22. Name and Address of Facility: Hardesty Funeral Home, PA 12 Ridgley Avenue, Annapolis, MD 21401

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Rectal Carcinoma
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*
29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: H. Goldstein M.D.
29c. License number: D26743
29d. Date signed *(Month, Day, Year)*: 2/27/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H.D. Goldstein M.D. 205 Ridgely Ave Annapolis, Md 21401

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 - 1999
32. Registrar's Signature: G. Hopkins

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06296

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Scott Sr.
2. Date of Death (Month Day Year): March 1, 1999
3. Time of Death: 12:45 pm
4a. Facility Name (If not institution, give street and number): Crofton Conv. Center
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 065-01-4252
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 30, 1910
9. Birthplace (State or Foreign Country): Ireland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Crofton
10d. Inside City Limits: 1 [ ] Yes X [X] No
10a. Street and Number: 2131 Davidsonville Road
10f. Zip Code: 21114
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plasterer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Anthony Scott
18. Mother's Name (First, Middle, Maiden Surname): May Kate Clarke

19a. Informant's Name/Relationship (Type, Print): William A. Scott - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1014 Howard Grove Court, Davidsonville, MD 21035

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Charles Cemetery
Date: 03/05
20c. Location - City or Town, State: Farmingdale, NY

21. Signature of Funeral Service Licensee: ▶ Kimberly S. Pope
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — Approximate Interval Between Onset and Death: 3 months
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Parkinsons Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D35848
29d. Date signed (Month, Day, Year): 3/1/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard K Schultz Jr. 1438 Defense Hwy Gambrills MD 21054

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

RKD
99-1127-041

FLORYAN
SCHULTZ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06297

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Floryan T. Schultz
2. Date of Death Month Day Year: FEBRUARY 26, 1999
3. Time of Death: 11:00A.M.
4a. Facility Name (If not institution, give street and number): EASTON MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: EASTON
4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 218-07-5664
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): March 6, 1921
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10e. State: MD
10b. County: Talbot
10c. City, Town or Location: Easton Maryland
10d. Inside City Limits: 1☐ Yes XX No
10e. Street and Number: 94 Park Lane
10f. Zip Code: 21601
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2☐ No If Yes, Give Year or Dates: Army 46-47
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Longshoreman
16b. Kind of Business/Industry: Shipping
17. Father's Name (First, Middle, Last): Henry Schultz
18. Mother's Name (First, Middle, Maiden Surname): Estella Main
19a. Informant's Name/Relationship (Type, Print): Michael T. Schultz / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 212 New Jersey Road, Stevensville Maryland 21666
20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Cross Cemetery, March 2, 1999
20c. Location - City or Town, State: Baltimore Maryland
21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☑ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year): 2-26-99
28b. Time of Injury: 0950 M
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred: Driver auto - truck collision
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Roadway
28f. Location (Street and Number or Rural Route Number, City or Town, State): Rt 404

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): FEBRUARY 27, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06298

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE RICHARD SMITH
2. Date of Death: Month FEBRUARY Day 25 Year 1999
3. Time of Death: 23:42
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-26-2039
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 13, 1932
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3704 ELDERON AVENUE
10f. Zip Code: 21215
10g. Citizen of What Country? USA.

To Be Completed by Funeral Director

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 2-23-51 3-4-54
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONTRACTOR
16b. Kind of Business/Industry: SELF-EMPLOYED
17. Father's Name (First, Middle, Last): THOMAS H. SMITH
18. Mother's Name (First, Middle, Maiden Surname): HORTENSE BLACKSTON
19a. Informant's Name/Relationship (Type, Print): JOY TARTER-SMITH (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3704 ELDERON AVE., BALTIMORE, MD. 21215
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST
Date: 03-05-99
20c. Location - City or Town, State: OWINGS MILLS, MD.
21. Signature of Funeral Service Licensee: D. Brown
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. Acute Pulmonary Edema — Approximate Interval Between Onset and Death: thirty minutes

Due to (or as a consequence of): b. Hypertensive Heart Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. Renal Failure — Years

Due to (or as a consequence of): d. Respiratory Lung Disease — Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Goiter

Obesity

Pheripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Larry S. Perry M.D.
29c. License number: 022031
29d. Date signed (Month, Day, Year): 2-26-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Larry S. Perry M.D. 2116 Maryland Ave Balto. Md 21218

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: Gwen B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4+1 UP

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06299

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ZENOBIA MARGARET STRAITEN
2. Date of Death: Month FEBRUARY Day 27 Year 1999
3. Time of Death: 19:35 PM
4a. Facility Name (If not institution, give street and number): 1100 PENNSYLVANIA AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-32-8332
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 24, 1911
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1100 PENNSYLVANIA AVE, APT. 514
10f. Zip Code: 212
10g. Citizen of What Country? USA.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4 or 5+): 2 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRACTICAL NURSE
16b. Kind of Business/Industry: NURSING HOME

17. Father's Name (First, Middle, Last): MELTON C. BROOKS
18. Mother's Name (First, Middle, Maiden Surname): JULIA MAE GALLOWAY

19a. Informant's Name/Relationship (Type, Print): WESLEY BROOKS (BROTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5310 WINNER AVENUE, BALTIMORE, MD. 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY
Date: 03-04-99
20c. Location - City or Town, State: ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee: John J. Williams
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cancer, unknown primary site — 2 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David M. Brown MD
29c. License number: D0040657
29d. Date signed (Month, Day, Year): March 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David M. Brown MD Univ. Health Ctr. 16 S. Eutaw St. Balto, Md. 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06300

Swain, James Webster

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Webster Swain
2. Date of Death (Month, Day, Year): February 19, 1999
3. Time of Death: 4:50pm
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 218-30-8494
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 12, 1933
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Hancock
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 13459 Millstone Circle
10f. Zip Code: 21750
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1955-61
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: Truck Manufacture
17. Father's Name (First, Middle, Last): William Webster Swain
18. Mother's Name (First, Middle, Maiden Surname): Maxine G. Schriver
19a. Informant's Name/Relationship (Type, Print): Eileen Swain/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13459 Millstone Circle Hancock, MD 21750
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Piney Plains Methodist
Date: 2/23/99
20c. Location - City or Town, State: Little Orleans, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750-0368

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Auto-Immune Hepatitis — (2) Month.
Due to (or as a consequence of):
b. Legionella pneumophila pneumonia. — (2) Weeks.
Due to (or as a consequence of):
c. Acute Renal failure — (2) Weeks.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D47288
29d. Date signed (Month, Day, Year): 02, 23, 99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Igbal 12821 Oak Hill Ave Hag. Md

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06301

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Teresa Smothers
2. Date of Death (Month, Day, Year): February 25, 1999
3. Time of Death: 8PM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-66-5124
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 5, 1954
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1417 N. Chester Street
10f. Zip Code: 21213
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Sam Colbert
16. Mother's Name (First, Middle, Maiden Surname): Theresa MacKenny
19a. Informant's Name/Relationship (Type, Print): Priscilla S. Smothers/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2223 Koko Lane Baltimore, MD 21216
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: 2/27/99
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Encephalopathy — Approximate Interval Between Onset and Death: 3 months
Due to (or as a consequence of):
b. Acquired Immune Deficiency Syndrome — 10 yrs
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pulmonary cavitation, Pneumocystis Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: P Barditch
29c. License number: D35701
29d. Date signed (Month, Day, Year): 2/26/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. BARDITCH 5200 EASTERN AVENUE, BALTIMORE, MD 21224

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06302

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Shirley Jean Smith
2. Date of Death (Month, Day, Year): FEB 28, 1999
3. Time of Death: 1:45 AM
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 264-55-4875
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 41 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 3, 1957
9. Birthplace (State or Foreign Country): Mississippi

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Forest Hill
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1603 Wileywood Court
10f. Zip Code: 21050
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Purchasing Agent
16b. Kind of Business/Industry: Electronics
17. Father's Name (First, Middle, Last): Raymond Kerr
18. Mother's Name (First, Middle, Maiden Surname): Mary Lanore Bush
19a. Informant's Name/Relationship (Type, Print): Stephen C. Smith/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1603 Wileywood Court Forest Hill, MD 21050
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. — Date: 3/1/99
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Edward A. Gregorchik — Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): e. Liver cancer — Approximate Interval Between Onset and Death: 1 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W Anthony Riley MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): February 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W A Riley GBMC 6701 N. Charles St Balto. MD 21204

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999

32. Registrar's Signature: [illegible]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

SHIRLEY SMITH FEBUARY 28, 1999 01:45AM

6 pgs

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06303

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James M. Swann
2. Date of Death: Month February Day 18 Year 1999
3. Time of Death: 5:16 PM
4a. Facility Name (If not institution, give street and number): 1509 Pentridge Rd
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Md

Funeral Director

5. Social Security Number: 219-16-3085
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-13-26
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1509 Pentridge Road
10f. Zip Code: 21239
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: beverage

17. Father's Name (First, Middle, Last): James Swann
18. Mother's Name (First, Middle, Maiden Surname): Angela Ford

19a. Informant's Name/Relationship (Type, Print): Florence Swann/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1509 Pentridge Road, Baltimore, Maryland 21239

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute MI	immediate
	Due to (or as a consequence of): Atherosclerosis	>1y
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stu B Bell MD
29c. License number: D22785
29d. Date signed (Month, Day, Year): 2/22/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart B Bell 3333 N. Calvert St Balt Md

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Brenda B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06304

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Parker Smith Jr.
2. Date of Death (Month, Day, Year): February 27, 1999
3. Time of Death: 2:50 p.m.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-09-4163
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09/28/1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5502 Todd Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Service Manager
16b. Kind of Business/Industry: Automobile
17. Father's Name (First, Middle, Last): William Parker Smith Sr.
18. Mother's Name (First, Middle, Maiden Surname): Alice Eikenbrode
19a. Informant's Name/Relationship (Type, Print): Barbara Cherewko
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1701 Commons Ct. Baltimore, Maryland 21237
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date:
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: ▶ Betty M. Blyde
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Smith, William

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease — 1 year

Due to (or as a consequence of):

b. Altered Mental Status — 6 months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D 45475
29d. Date signed (Month, Day, Year): 2-27-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Mohammad R. Rahnama, 9000 Franklin Square Drive, Baltimore, MD 21237

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: ▶ G. Apple

5 (cf)

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06305

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alphonso A. Thompson
2. Date of Death (Month, Day, Year): February 25, 1999
3. Time of Death: 3:40 AM
4a. Facility Name (If not institution, give street and number): 2053 N. Bentalou St.
4b. City, Town, or Location of Death: 21216
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-07-3857
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 2, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2053 N. Bentalou St.
10f. Zip Code: 21216
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Christian Minister
16b. Kind of Business/Industry: U.M. Church

17. Father's Name (First, Middle, Last): George Thompson
18. Mother's Name (First, Middle, Maiden Surname): Mary Hutton

19a. Informant's Name/Relationship (Type, Print): Mrs. Eloise Dalton (niece)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3615 Cottage Ave. Balto. Md. 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion
Date: 3/2/99
20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. COPD, end-stage
Due to (or as a consequence of):
b. CHF
Due to (or as a consequence of):
c. cardiomyopathy
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Payne, M.D.
29c. License number: D-19528
29d. Date signed (Month, Day, Year): 2/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ELMO M. PAYNE 541 Old Frederick Road Balto. Md. 21229

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06306

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVA THOMAS
2. Date of Death: Month 02 Day 22 Year 99
3. Time of Death: 8AM
4a. Facility Name (If not institution, give street and number): IRVINGTON KNOLLS NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: UNKNOWN
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-9-10
9. Birthplace (State or Foreign Country): NEW YORK

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 5837 BELAIR ROAD
10f. Zip Code: 21206
10g. Citizen of What Country?: USA.
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC ENGINEER
16b. Kind of Business/Industry: UNKNOWN
17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN
19a. Informant's Name/Relationship (Type, Print): SARAH BLACKSTON (FRIEND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2723 SPAULDING AVENUE, BALTIMORE, MD. 21215
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT ZION CEMETERY
Date: 02-26-99
20c. Location - City or Town, State: LANSDOWNE, MD.
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Atrial Fibrillation

Due to (or as a consequence of):
b. Arrythmia with Pacemaker

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. Chronic obstructive Pulm disease

Due to (or as a consequence of):
d. Peripheral vascular disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia
Left above knee amputation
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D31464
29d. Date signed (Month, Day, Year): 2/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHOALIB A HASHMI MD, 821 N. Eutaw Street Suite 308 Balt MD 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06307

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHRISTOPHER C. VENEY
2. Date of Death (Month, Day, Year): FEBRUARY 23, 1999
3. Time of Death: 17:37
4a. Facility Name (If not institution, give street and number): ST. AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 230-14-9503
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 23, 1923
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 8 N. GILMORE STREET
10f. Zip Code: 21223
10g. Citizen of What Country?: USA.

To Be Completed by Funeral Director

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 1ST GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: ROCK & PAVEMENT Co.
17. Father's Name (First, Middle, Last): WILLIAM THOMAS VENEY
18. Mother's Name (First, Middle, Maiden Surname): LILY SAVOY
19a. Informant's Name/Relationship (Type, Print): VIRGINIA CARSON (NIECE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 N. GILMORE STREET, BALTIMORE, MD. 21223
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY
Date: 03-01-99
20c. Location - City of Town, State: ARBUTUS, MARYLAND
21. Signature of Funeral Service Licensee: ▶ J. Brown
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Myocardial Infarction — Approximate Interval Between Onset and Death: 5 hours
Due to (or as a consequence of):
b. Atherosclerotic cardiovascular disease — years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Kevin H. Scruggs
29c. License number: D38543
29d. Date signed (Month, Day, Year): February 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KEVIN H. SCRUGGS MD 900 Caton Avenue Baltimore, Maryland 21229

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ Lawrence B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME: Christopher Veney

WR 2

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 9 per F.H G-769 3/2/99 reb

Certificate of Death

Reg. No. 99 06308

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JESSIE WILLIAMS
2. Date of Death: Month FEBRUARY Day 25TH Year 1999
3. Time of Death: 9:15PM
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 240442447-A
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9/22/1932
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1545 Glen Eagle Road
10f. Zip Code: 21239
10g. Citizen of What Country?: USA
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER
16b. Kind of Business/Industry: Georgia Pacific Paper Supply
17. Father's Name (First, Middle, Last): James Williams
18. Mother's Name (First, Middle, Maiden Surname): ETHEL
19a. Informant's Name/Relationship (Type, Print): Lovie Williams - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1545 Glen Eagle Rd. Balto. Md. 21239
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery | Date: 3-2-99
20c. Location - City or Town, State: Woodlawn, Maryland
21. Signature of Funeral Service Licensee: Jeff Miller
22. Name and Address of Facility: Jeff Miller P.C. Funeral Home & Services 1639 N. Broadway

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASPIRATION PNEUMONIA — 2 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MEDICAL DOCTOR
29c. License number: D0052277
29d. Date signed (Month, Day, Year): FEBRUARY 25TH 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS KWASHIE ATTIOGBE THE GOOD SAMARITAN HOSPITAL OF MARYLAND INC.

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: Bonnie B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 19a per F.H G-769 3/5/99 reb

Certificate of Death

Reg. No. 99 06309

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MELVIN K. WAGNER
2. Date of Death: Month MARCH Day 1 Year 1999
3. Time of Death: 11: 11 AM
4a. Facility Name (If not institution, give street and number): ST AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-20-9492
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 70 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02/12/1929
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: CATONSVILLE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2 SLATE MILLS CT.
10f. Zip Code: 21228
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ACCOUNTANT
16b. Kind of Business/Industry: ACCOUNTING SELF-EMPLOYED
17. Father's Name (First, Middle, Last): GEORGE WAGNER
18. Mother's Name (First, Middle, Maiden Surname): ANNA STACKS
19a. Informant's Name/Relationship (Type, Print): JAQUELYNN J. ~~JACQUELINE~~ WAGNER/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 SLATE MILLS CT. CATONSVILLE, MD 21228
20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) ENTOMBMENT
20b. Place of Disposition (Name of cemetery, crematory or other place): LORRAINE PARK CEMETERY
Date: 3/5/99
20c. Location - City or Town, State: WOODLAWN, MD
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Myocardial infarction — unknown

Due to (or as a consequence of):
b. atherosclerotic cardiovascular disease — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D47353
29d. Date signed (Month, Day, Year): March 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jon Falck MD St. Agnes Hospital 900 Caton Avenue Baltimore, Maryland 21229

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Melvin Wagner

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ [signature]

10+1 rdb

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06310

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louise M. Weicker

2. Date of Death: Month February Day 27 Year 1999

3. Time of Death: 5:15PM

4a. Facility Name (If not institution, give street and number): College Manor, Inc.

4b. City, Town, or Location of Death: Lutherville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 577-01-3115

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08/21/1910

9. Birthplace (State or Foreign Country): RI

Usual Residence of Decedent

10a. State: FL

10b. County: Palm Beach

10c. City, Town or Location: Boynton Beach

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 725 S.W. 18TH Court

10f. Zip Code: 33426

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Telephone Operator

16b. Kind of Business/Industry: Washington D.C. C & P Telephone Co.

17. Father's Name (First, Middle, Last): Charles Dawson

18. Mother's Name (First, Middle, Maiden Surname): Margaret Hayes

19a. Informant's Name/Relationship (Type, Print): George Weicker, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 725 S.W. 18TH Court Boynton Beach, FL 33426

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore-Washington Crematory

Date: 3/2/99

20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: ▶ Mary K. Marshall

22. Name and Address of Facility: Sterling-Ashton-Schwab Funeral Home, Inc. 736 Edmondson Ave. Catonsville, MD 21228

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary arrest

Due to (or as a consequence of):

b. progressive debility, weakness

Due to (or as a consequence of):

c. Advanced age, Dementia

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) College Manor

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Timothy Souweine MD

29c. License number: 024732

29d. Date signed (Month, Day, Year): 3/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy Souweine, M.D. 515 Fairmount Ave. Towson, MD 21286

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999

32. Registrar's Signature: ▶ [illegible]

DHMH 16 Rev 6/95

99-1133-510
SEAN WHITTEMORE
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, 28A-F PER MEO G769 3-9-99 W

Certificate of Death

99 06311
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SEAN OLIVER WHITTEMORE
2. Date of Death (Month, Day, Year): FEBRUARY 27 1999
3. Time of Death: 1:00 A
4a. Facility Name (If not institution, give street and number): 2231 PELHAM AVE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-76-8599
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 28 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): JAN. 23, 1971
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2231 PELHAM AVENUE
10f. Zip Code: 21213
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PHYSICAL THERAPIST AID
16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): JAMES RICHARD WHITTEMORE SR.
18. Mother's Name (First, Middle, Maiden Surname): OLIVIA LEE PRICE

19a. Informant's Name/Relationship (Type, Print): OLIVIA L. WHITTEMORE (MOTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2231 PELHAM AVENUE, BALTIMORE, MARYLAND 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARKWOOD CEMETERY
Date: 3/2/99
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Brian D. Fries
22. Name and Address of Facility: SCHIMUNEK FUNERAL HOME INC. 3331 BREHMS LANE, BALTIMORE, MARYLAND 21213

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined
28a. Date of Injury (Month, Day Year): Found: 2-27-99
28b. Time of Injury: Found: 12:55 A M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND AT RESIDENCE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 2231 PELHAM AVE. BALTIMORE, MARYLAND
29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): FEBRUARY 27,1999
30. Name and address of person who completed cause of death (item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: Bernice B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06312

ELLIS G. WELLINGTON

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ellis G. Wellington
2. Date of Death (Month, Day, Year): February 25, 1999
3. Time of Death: 2:10 AM
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 130-12-6562
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR. 8, 1921
9. Birthplace (State or Foreign Country): CA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2500 W. BELVEDERE AVE. #719
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OPTICIAN
16b. Kind of Business/Industry: MEDICINE
17. Father's Name (First, Middle, Last): MOSES WELLINGTON
18. Mother's Name (First, Middle, Maiden Surname): BLANCHE MACHENBERG
19a. Informant's Name/Relationship (Type, Print): FRED WELLINGTON / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 STONEHENGE CIRCLE - BALTIMORE, MD 21208
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WELLWOOD CEMETERY
Date: 2/25/99
20c. Location - City or Town, State: PINELAWN, L.I., NY
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute thrombo embolic stroke — 1 day
Due to (or as a consequence of):
b. Atherosclerosis / peripheral vascular disease — 15 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive pulmonary disease
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [✓] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: AS 2402321 AK 9209
29d. Date signed (Month, Day, Year): February 25, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Asif Rafi; Sinai Hospital of Baltimore

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: [signature]

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06313

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MADELINE S. WALLACH
2. Date of Death (Month, Day, Year): FEBRUARY 26, 1999
3. Time of Death: 15:45 PM
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 091-42-7283
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 19, 1901
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: STEVENSON
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8601 PARK HEIGHTS AVENUE
10f. Zip Code: 21153
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): MAX SPIRO
18. Mother's Name (First, Middle, Maiden Surname): ANNA HIRSH

19a. Informant's Name/Relationship (Type, Print): DR. EDWARD WALLACH / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8601 PARK HEIGHTS AVE; STEVENSON, MD 21253

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HILLTOP SERVICE CORP. Date: 3-1-1999
20c. Location - City or Town, State: TOWSON, MD

21. Signature of Funeral Service Licensee: ▶ Scott M. Cutler
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD; PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	two days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. CONGESTIVE HEART FAILURE	two years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Breast CANCER

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Justin L. Martin; Intern
29c. License number: RES-000
29d. Date signed (Month, Day, Year): February 26 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JUSTIN L. MARTIN, MD. JOHNS HOPKINS HOSPITAL, BALTIMORE MD 21287

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: ▶ [signature] G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06216

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET SELBY WACHTEL
2. Date of Death: Month February Day 25 Year 1999
3. Time of Death: 12:49 AM
4a. Facility Name (If not institution, give street and number): UNION MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 492-26-3655
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 92 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-27-1906
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 830 WEST 40th. STREET
10f. Zip Code: 21211
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4 YEARS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSE
16b. Kind of Business/Industry: HEALTH CARE

17. Father's Name (First, Middle, Last): BENJAMIN F. SELBY
18. Mother's Name (First, Middle, Maiden Surname): ANNA C. McQUAY

19a. Informant's Name/Relationship (Type, Print): ROBERT P.MELOCIK (FRIEND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8302 ALSTON ROAD,TOWSON,MARYLAND, 21204

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN MOUNT CREMATORY
Date: 3-3
20c. Location - City or Town, State: BALTO.,MD.,21202

21. Signature of Funeral Service Licensee: R. G. Rutt
22. Name and Address of Facility: HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD,BALTIMORE,MARYLAND,21212

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Influenza — Approximate Interval Between Onset and Death: 3days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Lymphocytic Leukemia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert C. Blackmon, M.D.
29c. License number: AT 2438946
29d. Date signed (Month, Day, Year): February 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Blackmon 201 East University Parkway, Baltimore, MD 21218

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Margaret Wachtel

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1999
32. Registrar's Signature: Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06315

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARRY WISE
2. Date of Death (Month, Day, Year): FEBRUARY 16 99
3. Time of Death: 00:33
4e. Facility Name (If not institution, give street and number): Johns Hopkins Bayview
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 216-50-0137
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 50 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 14, 1948
9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: unknown
10b. County: unknown
10c. City, Town or Location: unknown
10d. Inside City Limits: unknown 1 [ ] Yes 2 [ ] No
10e. Street and Number: unknown
10f. Zip Code: unknown
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1969-70
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown — College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper
16b. Kind of Business/Industry: Medical
17. Father's Name (First, Middle, Last): Harry Albert Wise, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Emily Nelson
19a. Informant's Name/Relationship (Type, Print): Howard W. Wise, brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1225 Steelton Avenue, Baltimore, Maryland 21224
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place) — Date
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. ADENOCARCINOMA OF RIGHT THIGH

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sarinder K Tuli MD
29c. License number: D27188
29d. Date signed (Month, Day, Year): 2/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sarinder K Tuli 2 Market Place Baltimore MD 21222

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06316

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wallace Wilson
2. Date of Death (Month, Day, Year): Feb 25 1999
3. Time of Death: 545PM
4a. Facility Name (If not institution, give street and number): Lorien Nursing Home
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 150-22-0363
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 11, 1918
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6620 Waning Moon Way
10f. Zip Code: 21045
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1942 1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction
16b. Kind of Business/Industry: Construction
17. Father's Name (First, Middle, Last): Thomas Wilson
18. Mother's Name (First, Middle, Maiden Surname): Ada White
19a. Informant's Name/Relationship (Type, Print): Mr. Howard Wilson Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6620 Waning Moon Way Columbia, Maryland 21045
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Restland Memorial Park
Date: 03/02/99
20c. Location - City or Town, State: East Hanover, New Jersey
21. Signature of Funeral Service Licensee: [signature] M00535
22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): e. myelodysplastic syndrome — Approximate Interval Between Onset and Death: 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

laryngeal Cancer
urinary infection

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D41617
29d. Date signed (Month, Day, Year): Feb 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary Kazlow 10805 Hickory Ridge Rd Columbia, Md 21044

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): MAR 02 1999
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 06317

Item#7 per FH G769 3/2/99 EW

Certificate of Death

Reg. No.

ZELMA ZHELEZNYAK

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ZELMA ZHELEZNYAK
2. Date of Death (Month, Day, Year): FEB. 27, 1999
3. Time of Death: 1:05 AM
4a. Facility Name (If not institution, give street and number): 6970 MARSUE DRIVE, APT. 2A
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-47-2933
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 61 ~~60~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 22, 1937
9. Birthplace (State or Foreign Country): UKRAINE

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6970 MARSUE DRIVE, APT. 2A
10f. Zip Code: 21215
10g. Citizen of What Country?: UKRAINE
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ENGINEER
16b. Kind of Business/Industry: ELECTRONICS
17. Father's Name (First, Middle, Last): MOISE KLEYMAN
18. Mother's Name (First, Middle, Maiden Surname): CELIA VAYNUNSKAYA
19a. Informant's Name/Relationship (Type, Print): ALEKSANDER ZHELEZNYAK/HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6970 MARSUE DR., APT.2A;BALTIMORE, MD 21215
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HAR SINAI | Date: 2-28-1999
20c. Location - City or Town, State: OWINGS MILLS, MD
21. Signature of Funeral Service Licensee: Scott M. Cutler
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD; PIKESVILLE, MD 21208

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

ZELMA ZHELEZNYAK

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hepatic failure — 3 mo.
Due to (or as a consequence of):
b. Metastatic Colon Cancer — 2 yrs.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cerebrovascular accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: P.O.
29c. License number: 44494
29d. Date signed (Month, Day, Year): 2-27-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

State Registrar

31. Date filed (Month, Day, Year): MAR 2 - 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

WRC
99-0825-031
JEANNE T.
ABBOTT
ITEMS. #23 PART I, 27 PER MEO G769 3-3-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06318

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jeanne T. Abbott
2. Date of Death (Month, Day, Year): FEB. 13, 1999
3. Time of Death: 12:31 PM.
4a. Facility Name (If not institution, give street and number): 502 LANARK WAY
4b. City, Town, or Location of Death: SILVERSPRING
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-14-2942
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 23, 1917
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 502 Lanark Way
10f. Zip Code: 20901
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Receptionist
16b. Kind of Business/Industry: National Geographics
17. Father's Name (First, Middle, Last): Frank L. Tyser
18. Mother's Name (First, Middle, Maiden Surname): Emma P. Fontan
19a. Informant's Name/Relationship (Type, Print): Joseph C. Tyser (nephew)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 109 Heil Road, Silver Spring, MD 20905
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery — Date: 2/18/99
20c. Location - City or Town, State: Silver Spring, MD
21. Signature of Funeral Service Licensee: ▶ J. Kevin Gutowski
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. SEPSIS AND PERITONITIS
Due to (or as a consequence of):
PERFORATION OF SMALL INTESTINE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Dennis J. Chute MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): FEB. 14, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99-0764-031
crn
Douglas Robert Abel
ITEMS: #23 PART I, 27 PER MEO G769 3-2-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06319

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOUGLAS ROBERT ABEL
2. Date of Death (Month Day Year): February 09, 1999
3. Time of Death: 6:46 P.M.
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-08-2055
6. Sex: 1☐ M 2☐ F X
7. Age (In yrs. last birthday): 16 Yrs.
If Under 1 Year: Months Days
If Under 24 Hrs.: Hours Min.
8. Date of Birth (Month, Day, Year): Jan 26, 1983
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☐ No X
10e. Street and Number: 18717 Shremor Drive
10f. Zip Code: 20855
10g. Citizen of What Country?: United States
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No X If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No X Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student - Sophomore Year
16b. Kind of Business/Industry: High School/ Education
17. Father's Name (First, Middle, Last): Brian R. Abel
18. Mother's Name (First, Middle, Maiden Surname): Linda Sheffer
19a. Informant's Name/Relationship (Type, Print): Brian & Linda Abel, Parents
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18717 Shremor Drive, Rockville, MD 20855
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery
Date: Feb 13, 1999
20c. Location - City or Town, State: York, Pennsylvania
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. RIGHT VENTRICULAR DYSPLASIA OF THE HEART

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No X 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes X 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes X 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient X 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural X 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. X

29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): February 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06320

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hilda Anderson
2. Date of Death: Month Feb Day 14 Year 1999
3. Time of Death: 3:30 pm
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 579-58-6264
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 27, 1906
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5400 Vantage Point Road
10f. Zip Code: 21044
10g. Citizen of What Country? United States
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): State Department
16b. Kind of Business/Industry: Federal Government
17. Father's Name (First, Middle, Last): Olams Anderson
18. Mother's Name (First, Middle, Maiden Surname): Annette Axelson
19a. Informant's Name/Relationship (Type, Print): Ed Love (Attorney)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4816 Moorland Lane, Bethesda, MD 20814
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 2/15/99
20c. Location - City or Town, State: Alexandria, Virginia
21. Signature of Funeral Service Licensee: Robert M. DeVol
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Aspiration pneumonia — Approximate Interval Between Onset and Death: 2 hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Myocardial infarction

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Bruce Conger Internist
29c. License number: D37013
29d. Date signed (Month, Day, Year): Feb 14, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bruce M Conger MD #210 11055 Little Patuxent Pkwy Columbia MD 21044

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06321

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nannette Elizabeth Arnott
2. Date of Death (Month, Day, Year): February 13, 1999
3. Time of Death: 7:15 PM
4a. Facility Name (If not institution, give street and number): Care Matrix of Silver Spring
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 298-10-0833
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 21, 1911
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Virginia
10b. County: Fairfax
10c. City, Town or Location: Annandale
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6800 Algonquin Court
10f. Zip Code: 22003
10g. Citizen of What Country?: United States
11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accounting Clerk
16b. Kind of Business/Industry: Bureau of Ships
17. Father's Name (First, Middle, Last): Charles G. Arnott
18. Mother's Name (First, Middle, Maiden Surname): Jessie D. Bowman
19a. Informant's Name/Relationship (Type, Print): Irene J. Hart (POA)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6800 Algonquin Court, Annandale, Virginia 22003
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ellsworth Cemetery
Date: 2-17-99
20c. Location - City or Town, State: Ellsworth, Ohio
21. Signature of Funeral Service Licensee: ▶ Carol A Delm
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Deep Vein Thrombosis
Anemia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Merlyn Vemury MD
29c. License number: D-35791
29d. Date signed (Month, Day, Year): February 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Merlyn K. Vemury, M.D., 9801 Georgia Avenue, #227, Silver Spring, Maryland 20902

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

99-0804-031
B.K.S
TERRY A. ATWOOD
ITEMS: #23 PART I, 27, 28A-F PER MEO G769 3-2-99 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06322

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TERRY ALAN ATWOOD
2. Date of Death (Month, Day, Year): FEB. 11, 1999
3. Time of Death: 3:18 PM
4a. Facility Name (If not institution, give street and number): SURBURBAN HOSPITAL E.R.
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 344-40-6432
6. Sex: 1 [X] M 2 [ ] F
7. Age (in yrs. last birthday): 48 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 21,1950
9. Birthplace (State or Foreign Country): MICHIGAN

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: BETHESDA
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6405 WILSON LA.
10f. Zip Code: 20817
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COMPUTER SYSTEMS ENGINEER
16b. Kind of Business/Industry: COMPUTERS
17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): ELDORA FREDERICKSON
19a. Informant's Name/Relationship (Type, Print): KATHERINE ATWOOD/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHAMBERS CREMATORY
Date: 2/18/99
20c. Location - City or Town, State: RIVERDALE, MD.
21. Signature of Funeral Service Licensee: W.W. Chambers MO0091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES,P.A., SILVER SPRING, MD. 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MULTIPLE INJURIES
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 2-11-99
28b. Time of Injury: 7:22 A M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: DRIVER OF VEHICLE HIT TREE
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): ROADWAY
28f. Location (Street and Number or Rural Route Number, City or Town, State): CLARA BARRON PARKWAY, BETHESDA MD.
29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. Pestaner, M.D.
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): FEB. 12, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06323

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RIVI L. BECK
2. Date of Death: Month 2 Day 15 Year 1999
3. Time of Death: 8:45 AM
4e. Facility Name (If not institution, give street and number): 15115 INTERLACHEN DRIVE #803
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577.07.1207
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 80 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06.04.1918
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10e. State: MARYLAND
10b. County: MONTOGMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15115 INTERLACHEN DRIVE #803
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): JOSEPH LEVINE
18. Mother's Name (First, Middle, Maiden Surname): LEAH HOROWITZ

19e. Informant's Name/Relationship (Type, Print): ALAN BECK/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 WATERVIEW DRIVE, PORT JEFFERSON, NY 117777

20e. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING DAVID MEMORIAL GDNS
Date: 2.17.99
20c. Location - City or Town, State: FALLS CHURCH, VA

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic adenocarcinoma of lung — 3 1/2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Matilda H. So, MD
29c. License number: D26250
29d. Date signed (Month, Day, Year): 2/16/1999

30. Name and address of person completed cause of death (Item 23a) (Type, Print): MATILDA H. SO, M.D. 10810 CONNECTICUT AVE, KENSINGTON, MD. 20895.

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #4c,2/18/99,BMW,Montg.Co.per physician

Certificate of Death

Reg. No. 99 06324

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET LAUGHLIN BELCHER
2. Date of Death: Month FEBRUARY Day 13 Year 1999
3. Time of Death: 1506
4a. Facility Name (If not institution, give street and number): 16600 GEORGE WASHINGTON DRIVE
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: ~~20853~~ Montgomery

Funeral Director

5. Social Security Number: 402-32-9268
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 7, 1928
9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 16600 George Washington Drive
10f. Zip Code: 20853
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1951-52
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Analyst
16b. Kind of Business/Industry: Federal Government
17. Father's Name (First, Middle, Last): Archibald A. Spalding
18. Mother's Name (First, Middle, Maiden Surname): Mary E. Bowling
19a. Informant's Name/Relationship (Type, Print): Thomas F. Belcher (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20853: 16600 George Washington Drive, Rockville, MD
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: 2/18/99
20c. Location - City or Town, State: Silver Spring, MD
21. Signature of Funeral Service Licensee: Steven D Strand
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

CARCINOMA OF BREAST

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD (OME)

29c. License number: 015236

29d. Date signed (Month, Day, Year): FEBRUARY 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL I. MARGOLIN, MD 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06325

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Aloysius Michael Bello, Sr.
2. Date of Death: Month February, Day 17, Year 1999
3. Time of Death: 3:24 A
4e. Facility Name (If not institution, give street and number): Levindale Rehabilitation Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 220-09-2464
6. Sex: 1☐ M 2☐ F — XX
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 29, 1922
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4201 Jefferson Street
10f. Zip Code: 20781
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married XX Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2☐ No — If Yes, Give Year or Dates: 1943-1949
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Management
16b. Kind of Business/Industry: Amtrac
17. Father's Name (First, Middle, Last): Michael A. Bello, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Anna Maria Torrillo
19e. Informant's Name/Relationship (Type, Print): Michael W. Bello (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9532 Nightsong Lane Columbia, Maryland 21046
20e. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery — Date: 2/20/1999
20c. Location - City or Town, State: Silver Spring, MD
21. Signature of Funeral Service Licensee: ▶ Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Respiratory Failure — 10/98

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Chronic Obstructive Pulmonary Disease years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure
Cardiomyopathy

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Debra Wertheimer MD
29c. License number: D23767
29d. Date signed (Month, Day, Year): February 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DEBRA S WERTHEIMER MD 2434 W. Belvedere Ave, Balto, MD 21215

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: Jenna G. Sparks

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Bello, Aloysius

10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06326

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM EDWARD BENTON
2. Date of Death: Month FEBRUARY Day 14 Year 1999
3. Time of Death: 0316
4a. Facility Name (If not Institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-10-9156
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUGUST 8, 1918
9. Birthplace (State or Foreign Country): WASHINGTON, DC

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1416 CAVENDISH DRIVE
10f. Zip Code: 20905
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MAIL HANDLER
16b. Kind of Business/Industry: US POSTAL SERVICE

17. Father's Name (First, Middle, Last): JOHN GARFIELD BENTON
18. Mother's Name (First, Middle, Maiden Surname): LOTTIE MARY BOAZ

19a. Informant's Name/Relationship (Type, Print): ROBERT G. BENTON/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1416 CAVENDISH DRIVE SILVER SPRING, MD 20905

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FT. LINCOLN CREMATORY
Date: 2/19/99
20c. Location - City or Town, State: BRENTWOOD, MD

21. Signature of Funeral Service Licensee: Anthony S. DiMyo
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
COPD, ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M.D (OME)
29c. License number: 015236
29d. Date signed (Month, Day, Year): FEBRUARY 14, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL I. MARGOLIS, MD. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06327

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Fredric A. Bernard, Jr.

2. Date of Death (Month, Day, Year): February 15, 1999

3. Time of Death: 22:50

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville MD

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 080-18-9498

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 21, 1923

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10 Orchard Way North

10f. Zip Code: 20854

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: University

17. Father's Name (First, Middle, Last): Fredric A. Bernard, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Althea Taylor

19a. Informant's Name/Relationship (Type, Print): Elsa Bernard / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Orchard Way North, Rockville, Maryland 20854

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: February 20, 1999

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Barbara J. McMullen Lawrence M00831

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pontine Hemorrhage (cerebrovascular) — Approximate Interval Between Onset and Death: 4 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David Holden MD

29c. License number: D47791

29d. Date signed (Month, Day, Year): February 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David A. Holden. M.D. 809 Veirs Mill Road, Rockville, Maryland 20851

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(B)

1541

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06328

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martha Claire Bittle
2. Date of Death (Month, Day, Year): February 15, 1999
3. Time of Death: 4:30 AM
4a. Facility Name (If not institution, give street and number): 2145 Edgeware Street
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 410-56-3414
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 61 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 5, 1937
9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomey
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2145 Edgeware Street
10f. Zip Code: 20905
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Systems Analyst
16b. Kind of Business/Industry: US Public Health Services

17. Father's Name (First, Middle, Last): John Usher Barker, II
18. Mother's Name (First, Middle, Maiden Surname): Nell Carter

19a. Informant's Name/Relationship (Type, Print): William Edward Bittle (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2145 Edgeware Street, Silver Spring, Maryland 20905

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Marys Cemetery
Date: 2-18-99
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Carol A Dehn
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Breast Cancer — 5 Years
Due to (or as a consequence of):
Respiratory Arrest

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Isabelle Martire
29c. License number: D45014
29d. Date signed (Month, Day, Year): February 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Isabelle Martire, M.D., 8379 Cherry Lane, Laurel, Maryland 20707

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Jenna G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

15

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06329

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALBERTA E. BLAIR
2. Date of Death (Month Day Year): FEBRUARY 14, 1999
3. Time of Death: 2:29 AM

4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 198-18-4680
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): AUG. 26, 1925
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD
10b. County: PRINCE GEORGES
10c. City, Town or Location: HYATTSVILLE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2414 GRIFFIN ST.
10f. Zip Code: 20783
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CHEMIST
16b. Kind of Business/Industry: RESEARCH

17. Father's Name (First, Middle, Last): ALBERT EDLUND
18. Mother's Name (First, Middle, Maiden Surname): EDNA JOHNSON

19a. Informant's Name/Relationship (Type, Print): WILLIAM LANDERS (FRIEND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3353 OAK WEST DR. ELLICOTT CITY, MD 21043

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FT. LINCOLN CREMATORY | Date: 2-18-99
20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: HINES-RINALDI 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ENDSTAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE — ~25 yr
Due to (or as a consequenca of):
b.
Due to (or as a consequenca of):
c.
Due to (or es e consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M.S. Nayar
29c. License number: D-17874
29d. Date signed (Month, Day, Year): 2-14-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. M. NAYAR MD 3717-38 AVE COTTAGE CITY, MD 20722

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit stub.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06330

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES EDWARD BLOCH
2. Date of Death (Month, Day, Year): February 16, 1999
3. Time of Death: 3:30 P.M.
4a. Facility Name (If not institution, give street and number): 5524 Devon Road
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 416-36-4260
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): February 22, 1912
9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5524 Devon Road
10f. Zip Code: 20814
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: United States Government
17. Father's Name (First, Middle, Last): Edward James Bloch
18. Mother's Name (First, Middle, Maiden Surname): Melinda Shanks
19a. Informant's Name/Relationship (Type, Print): Anne E. Bloch/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5524 Devon Road, Bethesda, Maryland 20814
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery — Date: February 19, 1999
20c. Location - City or Town, State: Silver Spring, Maryland
21. Signature of Funeral Service Licensee: Michael F. Aiello — License: M00846
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Non Small Cell Carcinoma of Lung — Approximate Interval Between Onset and Death: 6 Weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Heart Disease

Chronic Brain Syndrome probably Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph A. Romeo
29c. License number: D09680
29d. Date signed (Month, Day, Year): February 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph A. Romeo, M.D., 5454 Wisconsin Avenue #925, Chevy Chase, Maryland 20815

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

8+1

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06331

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CELIA BRAND
2. Date of Death Month Dey Year: FEBRUARY 12, 99
3. Time of Death: 6:05 PM
4a. Facility Neme (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Deeth: RANDALLSTOWN
4c. County of Deeth: BALTIMORE

Funeral Director

5. Social Security Number: 081.10.1466
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Yeer: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Dey, Year): 03.30.1905
9. Birthplace (Stete or Foreign Country): NEW YORK

Usual Residence of Decedent

10e. Stete: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 7920 SCOTTS LEVEL ROAD
10f. Zip Code: 21208
10g. Citizen of What Country?: WHITE
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Black, White, etc. Specify: WHITE
15. Decedent'e Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): OWNER
16b. Kind of Business/Industry: RETAIL
17. Father's Name (First, Middle, Last): "UNOBTAINABLE"
18. Mother's Name (First, Middle, Melden Surname): "UNOBTAINABLE"
19e. Informant's Name/Relationship (Type, Print): JUDY ROTH/DAUGHTER
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6 CORNBURY COURT, OWINGS MILLS, MARYLAND 21117
20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removeel from State 4☐ Donetion 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or other place): BETH TFILOH CEMETERY
Date: 2.14.99
20c. Location - City or Town, State: BALTIMORE, MARYLAND
21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after death with the Meryland Department of Heelth end Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final diseese or condition resulting in death): a. CARDIAC ARREST

Due to (or as e consequence of):

Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Lest:

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as e consequence of):

c. PNEUMONIA

Due to (or es e consequence of):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

HYPERTENSION

DEMENTIA

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings evellable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ K.S. RAO M.D.

29c. License number: 043462

29d. Date signed (Month, Dey, Year): FEBRUARY 12, 1999

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): K.S. RAO M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

6

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: ▶ Denise B. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06332

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Myrtie Rix Burns
2. Date of Death (Month Day Year): February 14, 1999
3. Time of Death: 10:30 PM
4a. Facility Name (If not institution, give street and number): Mariner Health of Kensington
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 014-24-9122
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 31, 1909
9. Birthplace (State or Foreign Country): Vermont

Usual Residence of Decedent

10a. State:
10b. County:
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4844 Rockwood Parkway, NW
10f. Zip Code: 20016
10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Salem Hospital

17. Father's Name (First, Middle, Last): Leslie Chamberlin
18. Mother's Name (First, Middle, Maiden Surname): Abigail Rix

19a. Informant's Name/Relationship (Type, Print): Catherine Burns Gill (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4844 Rockwood Parkway, Washington, DC 20016

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory | Date: 4-15-99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Carol A Dehn
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Coronary Artery Disease	Years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertension	Years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D36046
29d. Date signed (Month, Day, Year): February 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John J. Merendino, Jr., M.D., 4701 Randolph Road, #216, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06333

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY MIDDLETON BROMWICH
2. Date of Death (Month Day Year): Feb.13, 1999
3. Time of Death: 7:30 p.m.
4a. Facility Name (If not institution, give street and number): 406 Seymour Ave.
4b. City, Town, or Location of Death: St. Michaels
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 548-12-2271 A
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 19, 1913
9. Birthplace (State or Foreign Country): Washington,D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: St. Michaels
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 406 Seymour Ave.
10f. Zip Code: 21663
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home
17. Father's Name (First, Middle, Last): John C. Middleton
18. Mother's Name (First, Middle, Maiden Surname): Mary Coyne
19a. Informant's Name/Relationship (Type, Print): William Porter Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3103 Northwood Rd. Fairfax. Virginia 22031
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Capitol Crematory — Date: Feb. 17, 1999
20c. Location - City or Town, State: Dover, Delaware
21. Signature of Funeral Service Licensee: Harrison E. Leonard
22. Name and Address of Facility: Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David A Stout, M.D.

29c. License number: D06804

29d. Date signed (Month, Day, Year): 2-17-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Allan Stout M.D. 219 S. Washington St. Easton, Maryland 21601

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999

32. Registrar's Signature: Geneva G. Sparks

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06334

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Irvin Grant Blake
2. Date of Death (Month, Day, Year): 02/13/99
3. Time of Death: 03:15
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital @ Easton
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 218-40-6025
6. Sex: [X] M [ ] F
7. Age *(In yrs. last birthday)*: 56 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 26, 1942
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Annes
10c. City, Town or Location: Grasonville
10d. Inside City Limits: [X] Yes [ ] No
10e. Street and Number: 5107 Main Street
10f. Zip Code: 21638
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Construction Company
17. Father's Name *(First, Middle, Last)*: Robert G. Blake
18. Mother's Name *(First, Middle, Maiden Surname)*: Nannie Baynard
19a. Informant's Name/Relationship *(Type, Print)*: Carla A. Blake, Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 313 North Street, Apt. 4, Easton, Md. 21601
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Male & Female Beneficial — Date: 2/20/99
20c. Location - City or Town, State: Burrisville, Md.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bennie Smith Funeral Home, P.O. Box 1687, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiac Arrest	Minutes
Due to (or as a consequence of): b.	Insulin Dependent Diabetes Mellitus	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Polio	Years
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D0005754
29d. Date signed *(Month, Day, Year)*: 2-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ralph E. Libby, MD, P.O. Box 458, Grasonville, Md. 21638

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Blake, Irvin
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Blake, Irvin
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06335

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francis Thomas Byrne
2. Date of Death (Month, Day, Year): February 17, 1999
3. Time of Death: 1915
4a. Facility Name (If not institution, give street and number): Kent & Queen Anne's Hospital
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 474-14-3278
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 10, 1918
9. Birthplace (State or Foreign Country): Kilkenny, MN

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Rock Hall
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 22746 Col. Leonard Road
10f. Zip Code: 21661
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No — If Yes, Give Year or Dates: 1942-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Industrial Manufacturing

17. Father's Name (First, Middle, Last): Thomas Patrick Byrne
18. Mother's Name (First, Middle, Maiden Surname): Mary Dudley

19a. Informant's Name/Relationship (Type, Print): Maureen Mary Byrne/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22746 Col. Leonard Road, Rock Hall, MD 21661

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. John Cemetery — Date: 2/22/99
20c. Location - City or Town, State: Rock Hall, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — Approximate Interval Between Onset and Death: 6 weeks
Due to (or as a consequence of):
b. MYELOFIBROSIS — 3 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MMM
29c. License number: D-13824
29d. Date signed (Month, Day, Year): 2-19-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John C. Seymour 122 Speer Road, Suite 5, Chestertown, MD 21620

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12 + 1

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06336

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul F. Boyd, Sr.
2. Date of Death: Month 2 Day 15 Year 99
3. Time of Death: 4:30P.M
4a. Facility Name (If not institution, give street and number): 3516 Littlestown Pike
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 167-14-7132
6. Sex: 1 ☐ M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 9,1919
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No
10e. Street and Number: 3516 Littlestown Pike
10f. Zip Code: 21158
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: Manufacture Home Tools
17. Father's Name (First, Middle, Last): William Boyd
18. Mother's Name (First, Middle, Maiden Surname): Cora Bowers
19a. Informant's Name/Relationship (Type, Print): Marie Boyd Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3516 Littlestown Pike Westminster,MD 21158
20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sunrise Cemetery
Date: 2/18,1999
20c. Location - City or Town, State: Harney,MD
21. Signature of Funeral Service Licensee: Richard Lucle J
22. Name and Address of Facility: Little's F.H.34 Maple Ave.Littlestown,PA17340

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. VENTRICULAR FIBRILLATION — Approximate Interval Between Onset and Death: MINUTES
Due to (or as a consequence of):
b. DM II new onset — 3 WKS
Due to (or as a consequence of):
c. COPD — YEARS
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Renzo Ricci MD
29c. License number: D25804
29d. Date signed (Month, Day, Year): 2/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RENZO RICCI MD 3125 BALTO BLVD FINKSBURG, MD 21048

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 20b, per F.D.
2/16/99, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06337

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francis Howard Barnes
2. Date of Death (Month, Day, Year): February 14, 1999
3. Time of Death: 10:48 A.M.
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 217-36-4045
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 29, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: New Windsor
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 15125 Barnes Road
10f. Zip Code: 21776
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Own Farm Dairy Farmer

17. Father's Name (First, Middle, Last): Frank W. Barnes
18. Mother's Name (First, Middle, Maiden Surname): Nola C. Reck

19a. Informant's Name/Relationship (Type, Print): Evelyn Barnes Wilhide Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15111 Barnes Road New Windsor, MD 21176

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Pipe Creek Cemetery
Date: 2/19/99 ~~1/19/99~~
20c. Location - City or Town, State: New Windsor, MD

21. Signature of Funeral Service Licensee: ▶ Jama B Coey
22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Acute Myocardial Infarction

Due to (or as a consequence of): b. Alzheimer disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Prostate Cancer

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Gerard A DelGrippo Jr MD
29c. License number: D41994
29d. Date signed (Month, Day, Year): 2/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gerard A DelGrippo Jr. 15 E Frederick St. Walkersville MD 21793

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06338

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harold E. Bolden
2. Date of Death (Month, Day, Year): February 3, 1999
3. Time of Death: 8:00a.m.
4e. Facility Name (If not institution, give street and number): 45 Delaware Ave. Apt. 8
4b. City, Town, or Location of Death: Hurlock
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 220-26-0983
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5/10/32
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Hurlock
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 45 Delaware Ave. Apt. 8
10f. Zip Code: 21643
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 52-54
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Medical Supply
16b. Kind of Business/Industry: Naval Regional Medical Center

17. Father's Name (First, Middle, Last): Reuben H. Bolden
18. Mother's Name (First, Middle, Maiden Surname): Nettie Evans Bolden

19a. Informant's Name/Relationship (Type, Print): Gwen Killette/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 310 Glen Oak Circle, Hurlock, MD 21643

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Eastern Shore Veterans
Date: 2/9
20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funeral Service Licensee: ▶ Michael F. Eskow
22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home P.O. Box 43, Federalsburg, MD 21632

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Congestive Heart failure — years

Due to (or as a consequence of):
b. dilated cardiomyopathy — years

Due to (or as a consequence of):
c. chronic renal failure — years

Due to (or as a consequence of):
d. Hypertension — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal cell carcinoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
28. Place of Death (Check only one): Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D0046020
29d. Date signed (Month, Day, Year): 2/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. Syed I. Ali, 506 Idlewild Ave. Easton, Maryland 21601

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 11 1999
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06339

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUSSELL G BENNETT
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 3:05 A.M.
4a. Facility Name (If not institution, give street and number): 7006 Sundays Lane
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 429-82-3780
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 55 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 10, 1944
9. Birthplace (State or Foreign Country): Arkansas

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7006 Sundays Lane
10f. Zip Code: 21702
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1965-85
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief, Army Medical Materiel
16b. Kind of Business/Industry: Federal Govnt
17. Father's Name (First, Middle, Last): Rufford Gordon Bennett
18. Mother's Name (First, Middle, Maiden Surname): Bessie Lorine Mitchell
19a. Informant's Name/Relationship (Type, Print): Betty Ellen Lee Bennett, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7006 Sundays Lane Frederick, Maryland 21702
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cumberland Valley Mem
Date: 2/15/99
20c. Location - City or Town, State: Carlisle, Pennsylvania
21. Signature of Funeral Service Licensee: Kenny R. Savage
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Malignant Melanoma — 20 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Casper E. Cline MD
29c. License number: D 16428
29d. Date signed (Month, Day, Year): 2/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Casper E. Cline MD 300 W. 9th Street, Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06340

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy A. Celec
2. Date of Death (Month, Day, Year): February 14, 1999
3. Time of Death: 7:00 AM
4a. Facility Name (If not institution, give street and number): Collingswood Nursing Center
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 054-20-0751
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 29, 1919
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 299 Hurley Avenue
10f. Zip Code: 20850
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Elgie Slaughter
18. Mother's Name (First, Middle, Maiden Surname): Isabelle Greenlaw

19a. Informant's Name/Relationship (Type, Print): Carol A. Penberthy/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 540 Azalea Drive, Rockville, Maryland 20850

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rockville Union Cemetery — Date: February 18, 1999
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: [signature] M01126
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — days

Due to (or as a consequence of):
b. Sepsis — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D53244
29d. Date signed (Month, Day, Year): February 14, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Katharine R. Lillie, MD — 11140 Rockville Pike #348 Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Dorothy Celec February 14, 1999 07:00 AM

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06341

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Patrick Clancy
2. Date of Death (Month, Day, Year): February 12, 1999
3. Time of Death: 9:10 PM
4a. Facility Name (If not institution, give street and number): Manor Care - Chevy Chase
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-10-9767
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Feb. 12, 1906
9. Birthplace (State or Foreign Country): Iowa

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2201 Colston Drive, Apt. 406
10f. Zip Code: 20910
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Wholesale Food Distribution
17. Father's Name (First, Middle, Last): George Joseph Clancy
18. Mother's Name (First, Middle, Maiden Surname): Jennie Stapleton
19a. Informant's Name/Relationship (Type, Print): Margaret B. Clancy (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2201 Colston Drive, Silver Spring, MD 20910
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: 2/16/99
20c. Location - City or Town, State: Silver Spring, MD
21. Signature of Funeral Service Licensee: William L Byl
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

(6)

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Pulmonary edema — Approximate Interval Between Onset and Death: 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Congestive heart failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

myelofibrosis hemachromotosis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Pinholt MD
29c. License number: D51015
29d. Date signed (Month, Day, Year): 2/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ellen Pinholt, M.D. 5530 Wisconsin Avenue, Chevy Chase, MD 20815

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

(10)

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06342

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia N. Claybrook
2. Date of Death: Month 02 Day 16 Year 99
3. Time of Death: 0540 am
4a. Facility Name (If not institution, give street and number): 9722 Corkran Lane
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 229-58-7362
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 10, 1903
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: VA
10b. County: Lancaster
10c. City, Town or Location: Kilmarnock
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 99 East Church Street
10f. Zip Code: 22482
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Caucasian
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postal Clerk
16b. Kind of Business/Industry: United States Postal Service
17. Father's Name (First, Middle, Last): Albert Noblett
18. Mother's Name (First, Middle, Maiden Surname): Cora Brent
19a. Informant's Name/Relationship (Type, Print): Charlotte Ostdiek - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9722 Corkran Lane, Bethesda, Maryland
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Morattico Baptist Church Cemetery — Date: 2/19/99
20c. Location - City or Town, State: Kilmarnock, VA
21. Signature of Funeral Service Licensee: Howard A Causey
22. Name and Address of Facility: Currie Funeral Home, Inc. PO Box 1275, Kilmarnock, Virginia 22482

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Cancer of colon — Approximate Interval Between Onset and Death: 5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia secondary to blood loss

Chronic renal insufficiency

Atrial fibrillation

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Daughter's Residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D07035
29d. Date signed (Month, Day, Year): 17 Feb 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Herman C. Maganzini, M.D. 15235 Shady Grove Rd. Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: Geneva G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

15

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06343

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE THOMAS COOR
2. Date of Death (Month, Day, Year): FEBRUARY 15, 1999
3. Time of Death: 18:56
4a. Facility Name (If not institution, give street and number): NORTH ANNE ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 021 24 3081
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 21, 1932
9. Birthplace (State or Foreign Country): MISSISSIPPI

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: OLNEY
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 18805 WILLOW GROVE ROAD
10f. Zip Code: 20832
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify: KOREAN
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FACTORY REPRESENTATIVE
16b. Kind of Business/Industry: BANK SECURITY

17. Father's Name (First, Middle, Last): SAMUEL THOMAS COOR
18. Mother's Name (First, Middle, Maiden Surname): NELLIE AGNEW

19a. Informant's Name/Relationship (Type, Print): ANNE PATRICIA COOR, WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18805 WILLOW GROVE ROAD, OLNEY, MD. 20832

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY
Date: 2/20/99
20c. Location - City or Town, State: SILVER SPRING, MD.

21. Signature of Funeral Service Licensee: ▶ Muriel H Barber
22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME, P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. CORONARY ARTERY DISEASE — Approximate Interval Between Onset and Death: 10 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Left Ventricular dysfunction

Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D26443
29d. Date signed (Month, Day, Year): February 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gregory H. Fisher, MD. 15225 Shady Grove Road, Gaithersburg, Maryland 20850

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: ▶ [signature] B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

JW

12+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 06344

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James C. Craig
2. Date of Death (Month, Day, Year): February 16, 1999
3. Time of Death: 1:12 PM
4a. Facility Name (If not institution, give street and number): Holy Cross Rehabilitation and Nursing Ctr.
4b. City, Town, or Location of Death: Burtonsville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 192-18-2408
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 14, 1910
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9403 Crosby Road
10f. Zip Code: 20910
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: 1942-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrator
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): John Bradford Craig
18. Mother's Name (First, Middle, Maiden Surname): Kathryn Lucille Carver

19a. Informant's Name/Relationship (Type, Print): Aileen J. Craig (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9403 Crosby Road, Silver Spring, MD 20910

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 2/17/99
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ Martin Pikal
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death) a. Aspiration pneumonia — 4 d

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Disease

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Myron L. Lenkin
29c. License number: D06674
29d. Date Signed (Month, Day, Year): 2/17/99

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): MYRON L. LENKIN MD — 2309 SHOREFIELD RD WHEATON, MD

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1571

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06345

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Toy Maine Crawford
2. Date of Death (Month, Day, Year): February 14, 1999
3. Time of Death: 6:04 AM
4a. Facility Name (If not institution, give street and number): Medlantic Manor/ Layhill Nursing Center
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 554-30-5687
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 25, 1904
9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2601 Bel Pre Road
10f. Zip Code: 20906
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): John S. Maine
18. Mother's Name (First, Middle, Maiden Surname): Margaret Jenkins
19a. Interment's Name/Relationship (Type, Print): Billie Jean Spille (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Commune DeLusignac, Verteillac, France, 24320
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 2/15/99
20c. Location - City or Town, State: Arlington, Virginia
21. Signature of Funeral Service Licensee: ▶ J. Kei Stiles
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute on Chronic Renal Failure — 2
Due to (or as a consequence of):
b. Atherosclerotic Heart Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
–

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Suresh Gupta
29c. License number: D14876
29d. Date signed (Month, Day, Year): 2·15·99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suresh C. Gupta, M.D., 4701 Randolph Road, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Geneva G. Sparks

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06346

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICIA L CROWN
2. Date of Death: Month FEB Day 14 Year 1999
3. Time of Death: 19:05
4a. Facility Name (If not institution, give street and number): Howard County General
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 214-42-5410
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 2 1944
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Clarksville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5395 Broadwater Lane
10f. Zip Code: 21029
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Paving Company
17. Father's Name (First, Middle, Last): Benjamin Barnhart
18. Mother's Name (First, Middle, Maiden Surname): Marion Brooks
19a. Informant's Name/Relationship (Type, Print): Kenneth L. Crown / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5395 Broadwater Lane, Clarksville, Maryland 21029
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): COLUMBIA MEMORIAL PARK | Date: 2/19/99
20c. Location - City or Town, State: CLARKSVILLE, MD.
21. Signature of Funeral Service Licensee: Muriel H. Barber
22. Name and Address of Facility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Maryland 20882

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at page.

JW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — Approximate Interval Between Onset and Death: hours
Due to (or as a consequence of):
b. pneumonia — days
Due to (or as a consequence of):
c. "flu" — ~7 days
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☑ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Patrice A Toye MD Deputy ME
29c. License number: D31473
29d. Date signed (Month, Day, Year): Feb 15, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRYCE A. TOYE, MD 4565 Hemlock Cone Way Ellicott City MD 21042

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06347

Ellen Conyer

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ellen L. Conyer
2. Date of Death: Month Feb Day 16 Year 1999
3. Time of Death: 8:05PM
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 217-42-5661
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 25, 1943
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: Easton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 10 Village Street, Apt.102
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seafood Shucker
16b. Kind of Business/Industry: Seafood Plant
17. Father's Name (First, Middle, Last): Tilghman Johnson
18. Mother's Name (First, Middle, Maiden Surname): Lillie Mae Scott
19a. Informant's Name/Relationship (Type, Print): John Henry Brown,Jr.,Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Village Street,Apt102, Easton,Maryland 21601
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Roseville Cemetery — Date: 2/20/99
20c. Location - City or Town, State: Hope,Maryland
21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: Bennie Smith Funeral Home P.O.Box 1687,Easton,Maryland 21601

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Uremia — Approximate Interval Between Onset and Death: > 7 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Diabetic glomerulosclerosis — > 9 yrs.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Multiple cerebral infarctions

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert W. Trever, M.D.

29c. License number: D 10938

29d. Date signed (Month, Day, Year): 2-17-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert W. Trever, M.D., 7696 Ocean Gateway, Easton, Md. 21601

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999

32. Registrar's Signature: ▶ Diane B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06348

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLARA DARLING CARMICHAEL
2. Date of Death (Month, Day, Year): February 13, 1999
3. Time of Death: 1430
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 526-18-4068
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): April 17, 1907
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: St. Michaels
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8513 Bozman-Neavitt Rd.
10f. Zip Code: 21663
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Army Nurse
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 6
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Health
17. Father's Name (First, Middle, Last): Thomas Darling
18. Mother's Name (First, Middle, Maiden Surname): Emma Childs McClintock
19a. Informant's Name/Relationship (Type, Print): Nancy W. Wheeler Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 68 Sunset Hill Dr. Branford, Connecticut 06405
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Capitol Crematory | Date: Feb. 15, 1999
20c. Location - City or Town, State: Dover, Delaware
21. Signature of Funeral Service Licensee: Harrison E. Leonard
22. Name and Address of Facility: Harrison E. Leonard Funeral Home, 312 S. Talbot St. St. Michaels, Maryland 21663

To Be Completed by Funeral Director

Clara Carmichael

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary arrest — minutes
Due to (or as a consequence of):
b. Perforated Ulcer — 2 days
Due to (or as a consequence of):
c. Metastatic adenocarcinoma — 11 days
Due to (or as a consequence of):
d. of the duodenum.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: SM Bysshe
29c. License number: D23066
29d. Date signed (Month, Day, Year): 2/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stanley M. Bysshe Jr. M.D. 505 Dutchmans Lane Easton, Maryland 21663

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06349

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Calvin Cook
2. Date of Death (Month, Day, Year): February 16, 1999
3. Time of Death: 2:15am
4a. Facility Name (If not institution, give street end number): Windsor Ridge Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-30-3604
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 22, 1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 3530 Resource Drive
10f. Zip Code: 21133
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): Edward Cook
18. Mother's Name (First, Middle, Maiden Surname): Eugenia Chase

19a. Informant's Name/Relationship (Type, Print): Mrs. Glennice M. Cook (wife)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3530 Resource Drive Randallstown, MD 21133

20a. Method of Disposition: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): White Rock Cemetery
Date: 2/19/99
20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: ▶ Brian L. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Renal Disease end stage — estimate 5 years
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): N/A
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D15872
29d. Date signed (Month, Day, Year): February 16 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HAROLD B. BUB 25 Main St. Reisterstown 21136

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ADH
99-0841-013
CASEY CARPENTER

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06350

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Casey Lynn Carpenter
2. Date of Death (Month, Day, Year): FEBRUARY 14, 1999
3. Time of Death: 1455 PM
4a. Facility Name (If not institution, give street and number): BARTHOLOW RD.N/O LINTON RD.
4b. City, Town, or Location of Death: ELDERSBURG
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 166-66-3924
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 14 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 26, 1984
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Marriottsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7423 Brangles Road
10f. Zip Code: 21104
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: Education
17. Father's Name (First, Middle, Last): Marion Edward Carpenter, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Sharon Lynn Wright
19a. Informant's Name/Relationship (Type, Print): Mr. Marion Edward Carpenter, Jr. (Father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7423 Brangles Road Marriottsville, MD 21104
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorial Park — Date: 2/17/99
20c. Location - City or Town, State: Sykesville, MD
21. Signature of Funeral Service Licensee: Brian L. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 2/14/99
28b. Time of Injury: 1333 HRS
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Passenger in vehicle that hit fixed object
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Roadway
28f. Location (Street and Number or Rural Route Number, City or Town, State): Bartholow Road North of Linton Road in Sykesville Maryland

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King
29c. License number: OCME
29d. Date signed (Month, Day, Year): FEBRUARY 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06351

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY LOUISE CLEMENTS
2. Date of Death: Month Febuary Day 12 Year 1999
3. Time of Death: 5:40 P.M.
4e. Facility Name (If not Institution, give street and number): CIVISTA MEDICAL CENTER
4b. City, Town, or Location of Death: LA PLATA
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 217-46-9536
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV.22, 1913
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10e. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: WALDORF
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2595 LAUREL BRANCH DRIVE
10f. Zip Code: 20603
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4or 5+): 0
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): CHARLES JOSEPH ULLMAN
18. Mother's Name (First, Middle, Maiden Surname): GRACE JOHANNA WINKLER

19e. Informant's Name/Relationship (Type, Print): BARBARA A. BUCKLER - DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2585 LAUREL BRANCH DRIVE, WALDORF, MARYLAND 20603

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. JOSEPH CHURCH CEM.
Date: FEB. 17,
20c. Location - City or Town, State: 1999, POMFRET, MD

21. Signature of Funeral Service Licensee: MGB Mark G. Brohawn — MARK G. BROHAWN M00053
22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O.BOX 156, WALDORF, MARYLAND 20604

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Cardiac Arrest — Approximate Interval Between Onset and Death: 3m
Due to (or as a consequence of):
b. Myocardial Infarction — 7 days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Cardiomyopathy — 2 yr
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Non insulin dependent diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): —
28b. Time of Injury: — M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: —
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): —
28f. Location (Street and Number or Rural Route Number, City or Town, State): —

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Arwoody MD
29c. License number: D - 11176
29d. Date signed (Month, Day, Year): 13 Feb 99 2-13-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arthur O. Wooddy, MD 100 Washington Avenue, P.O.Box 430, LaPlata, Maryland 20646

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Mary Louise Clements

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06352

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles C. Chaney Jr.
2. Date of Death (Month, Day, Year): February 10 1999
3. Time of Death: 3:09am
4a. Facility Name (If not institution, give street and number): St. Agnes Nursing & Rehabilitation Center
4b. City, Town, or Location of Death: Ellicott City
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 218-10-6094
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 27, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3649 Valley Road
10f. Zip Code: 21042
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Phone Company
17. Father's Name (First, Middle, Last): Charles C. Chaney
18. Mother's Name (First, Middle, Maiden Surname): Stella Clark
19a. Informant's Name/Relationship (Type, Print): Catherine C. Chaney/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3649 Valley Road Ellicott City, Maryland 21042
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 2-10-99
20c. Location - City or Town, State: Catonsville, MD
21. Signature of Funeral Service Licensee: Sharon A Collins-Witzke
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. pneumonia — 1 mo.

Due to (or as a consequence of): b. severe oral pharyngeal dysphagia — 1 mo.

Due to (or as a consequence of): c. cerebrovascular insufficiency — 2 yr.

Due to (or as a consequence of): d. mixed vascular degenerative disease — 1 yr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] physician
29c. License number: D29769
29d. Date signed (Month, Day, Year): February 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Maureline D. Albuerne 1120 W. Rolling Rd Balto.

State Registrar

31. Date filed (Month, Day, Year): FEB 10 1999
32. Registrar's Signature: [signature] G. Agatz

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06353

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CARL F. DAPHNEY
2. Date of Death (Month, Day, Year): FEB. 14, 1999
3. Time of Death: 9:15 PM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: MOTNGOMERY

Funeral Director

5. Social Security Number: 579-07-8254
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept.12,1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 616 Douglas Avenue
10f. Zip Code: 20850
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Refuge Co.
17. Father's Name (First, Middle, Last): Oscar Daphney
18. Mother's Name (First, Middle, Maiden Surname): Pearl Brown
19a. Informant's Name/Relationship (Type, Print): Clifton Lear (Brother-in-law)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 616 Douglas Ave., Rockville, MD 20850
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Norbeck Mem. Park — Date: 2/22/99
20c. Location - City or Town, State: Olney, MD
21. Signature of Funeral Service Licensee: George R. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction — Approximate Interval Between Onset and Death: Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cardiogenic Shock; Pulmonary Edema

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Martin C. Shargel M.D.
29c. License number: D08944
29d. Date signed (Month, Day, Year): Feb. 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martin C. Shargel, M.D. 3720 Farragut Ave., Kensington, MD 20895

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Donna G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06354

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Manlio Ferrero De Angelis
2. Date of Death (Month, Day, Year): Feb. 14, 1999
3. Time of Death: 9:45am
4a. Facility Name (If not institution, give street and number): 370 Russell Avenue
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 134-10-7174
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 17, 1914
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 370 Russell Avenue
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Ricciardo De Angelis
18. Mother's Name (First, Middle, Maiden Surname): Angela Carrucci

19a. Informant's Name/Relationship (Type, Print): Muriel De Angelis (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 370 Russell Avenue, Gaithersburg, MD 20877

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory — Date: 2/15/99
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Robert H. DeVol
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE MYELOGENOUS LEUKEMIA — 3 WEEKS

Due to (or as a consequence of): b. MYELODYSPLASTIC SYNDROME — 18 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James G. Brown, MD
29c. License number: D 07285
29d. Date signed (Month, Day, Year): FEBRUARY 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES G. BROWN, MD 9707 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Bruce G. Apple

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

15

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06355

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie M. Delisi
2. Date of Death (Month, Day, Year): February 14, 1999
3. Time of Death: 8:15 AM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-22-9353
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 28, 1909
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 10404 Hemley Lane
10f. Zip Code: 20902
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Ignacio Capannelli
18. Mother's Name (First, Middle, Maiden Surname): Sylvia Giannini

19a. Informant's Name/Relationship (Type, Print): Joseph V. Delisi (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 Kerwin Road, Silver Spring, MD 20901

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery — Date: 2/17/99
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Robert Ramsey
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. RENAL FAILURE — Approximate Interval Between Onset and Death: MONTHS
Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE — MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ATRIAL FIBRILLATION
CORONARY ARTERY DISEASE
AORTIC STENOSIS

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D36046
29d. Date signed (Month, Day, Year): 2/14/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN T. MERENDINO JR, MD — 4701 RANDOLPH RD #216 ROCKVILLE, MD 20852

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06356

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SARAH DERTADIAN
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 6:15 PM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 129-10-2666
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 10, 1912
9. Birthplace (State or Foreign Country): Turkey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3333 University Boulevard, West #510
10f. Zip Code: 20895
10g. Citizen of What Country?: U.S.A.

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Bedros Bedoyan
18. Mother's Name (First, Middle, Maiden Surname): Ovsanna Dervichian
19a. Informant's Name/Relationship (Type, Print): Richard N. Dertadian (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2800 Abilene Drive Chevy Chase, Maryland 20815
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: 02/16/99
20c. Location - City or Town, State: Silver Spring, MD
21. Signature of Funeral Service Licensee: James G. Dailey
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE

Due to (or as a consequence of):
b. INTERSTITIAL PULMONARY FIBROSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. RHEUMATOID LUNG DISEASE

Due to (or as a consequence of):
d. RHEUMATOID ARTHRITIS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ASTHMATIC BRONCHITIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Irving Mizus
29c. License number: D26571
29d. Date signed (Month, Day, Year): 2/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Irving Mizus, 4930 Del Ray Avenue, Bethesda, MD 20814

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Jenna G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

DERTADIAN, SARAH; 2/11/99 at 6:15 pm

2

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06357

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Wilkinson Day Desgalier
2. Date of Death (Month, Day, Year): February 12, 1999
3. Time of Death: 4:05 AM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-26-3867
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 10, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13116 Ewood Lane
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Montgomery County Public Schools

17. Father's Name (First, Middle, Last): S.E. Wilkinson
18. Mother's Name (First, Middle, Maiden Surname): Emma Pearl Buck

19a. Informant's Name/Relationship (Type, Print): Charlotte D. Matacia/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5119 White Flint Drive, Kensington, Maryland 20895

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park; Date: Feb. 15, 1999
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Roy Funk M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — Approximate Interval Between Onset and Death: 2 months
Due to (or as a consequence of):
b. Cerebrovascular Accident — 10 years
Due to (or as a consequence of):
c. Hypertension — 15 years
Due to (or as a consequence of):
d. Hypothyroidism — 8 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease
Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Wajeed Khan, MD
29c. License number: D32817
29d. Date signed (Month, Day, Year): February 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M Wajeed Khan MD 12016 Georgia Ave, Silver Spring, MD 20902

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06358

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHELDON DIENER
2. Date of Death: Month FEBRUARY Day 16 Year 1999
3. Time of Death: 1031
4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 118-24-4469
6. Sex: 1☐ M 2☐ F XX
7. Age (In yrs. last birthday): 65 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 18, 1933
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: Maryland
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: XX Yes 2☐ No
10e. Street and Number: 12505 MARIE COURT
10f. Zip Code: 20904
10g. Citizen of What Country?: U. S. A.
11. Marital Status: 1☐ Never Married 2XX Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YEARS; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESMAN
16b. Kind of Business/Industry: INSURANCE
17. Father's Name (First, Middle, Last): ABRAHAM DIENER
18. Mother's Name (First, Middle, Maiden Surname): YETTA SCHEER
19a. Informant's Name/Relationship (Type, Print): NEIL DIENER - SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 WATCHWATER WAY, ROCKVILLE, MARYLAND 20850
20a. Method of Disposition: 1XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): JUDEAN MEMORIAL GARDENS Date: 2/19/99
20c. Location - City or Town, State: OLNEY, MARYLAND
21. Signature of Funeral Service Licensee: Donald C. Stottlemyer
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD. 20852

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

(B)

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c. RENAL FAILURE

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4XX Unknown

24a. Was an autopsy performed? 1☐ Yes 2XX No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2XX No

25. Was case referred to medical examiner? 1XX Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2XX ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1XX Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2XX **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD (OME)
29c. License number: 015236
29d. Date signed (Month, Day, Year): FEBRUARY 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL I. MARGOLIS, MD. (OME) 11125 ROCKVILLE PIKE, ROCKVILLE MD 20852

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6 (14)

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06359

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Caroline Dinerman
2. Date of Death (Month, Day, Year): Feb 12 1999
3. Time of Death: 6:00 AM
4a. Facility Name (If not institution, give street and number): 12215 Pheasant Run Dr.
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 410-72-9510
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 2,1944
9. Birthplace (State or Foreign Country): Tenn.

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12215 Pheasant Run Dr.
10f. Zip Code: 20708
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant Tech.
16b. Kind of Business/Industry: Federal Government
17. Father's Name (First, Middle, Last): Ben Statum
18. Mother's Name (First, Middle, Maiden Surname): Margaret Yates
19a. Informant's Name/Relationship (Type, Print): Leonard Dinerman / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12215 Pheasant Run Dr. Laurel, MD 20708
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Lebanon Cemetery
Date: Feb. 14,99
20c. Location - City or Town, State: Adelphi, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Takoma Funeral Home 20012 254 Carroll St. N.W. Washington, DC

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Metastatic Breast Cancer	1 year
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 08754
29d. Date signed (Month, Day, Year): Feb. 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas A. Bensinger 7525 Greenway Ctr. Dr. #205 Greenbelt, MD 20770

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06360

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucy Elizabeth Downes
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 10:40pm
4a. Facility Name (If not institution, give street and number): Montgomery Care & Rehabilitation Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 227-09-4089
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 15, 1917
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Derwood
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 17812 Shady Mill Road
10f. Zip Code: 20855
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Lafitte Cameron
18. Mother's Name (First, Middle, Maiden Surname): Ida Holmes

19a. Informant's Name/Relationship (Type, Print): Joan E. Rikon (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17812 Shady Mill Road, Derwood, MD 20855

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery — Date: 2/15/99
20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: ▶ Robert H. DeVol
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. metastatic adenocarcinoma, colon — Approximate Interval Between Onset and Death: 4 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

insulin dependent diabetes mellitus, diaphrm, atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D33443
29d. Date signed (Month, Day, Year): February 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan R. Pollack, M.D. 809 Views Mill Rd Rockville, Md 20851

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06361

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hester Short Duff
2. Date of Death (Month, Day, Year): February 13 1999
3. Time of Death: 1421
4a. Facility Name (If not institution, give street and number): Union Hospital of Cecil County
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 218-38-3979
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 14, 1926
9. Birthplace (State or Foreign Country): Cecil Co., MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Earleville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 125 Foxes Lane
10f. Zip Code: 21919
10g. Citizen of What Country?: United States
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postmaster
16b. Kind of Business/Industry: U.S. Postal Service
17. Father's Name (First, Middle, Last): Joseph Short
18. Mother's Name (First, Middle, Maiden Surname): Mary Cannon
19a. Informant's Name/Relationship (Type, Print): Mr. Sam Duff, Jr./Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 101, Earleville, Maryland 21919
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Zion Cemetery
Date: February 17, 1999
20c. Location - City or Town, State: Cecilton, Maryland
21. Signature of Funeral Service Licensee: Gary B. Fellows
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 226 E. Main Street, Cecilton, Maryland 21913

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. aspiration pneumonia — Approximate Interval Between Onset and Death: 6 months
Due to (or as a consequence of):
b. dysphagia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

dementia
diabetes mellitus type 2
aplastic anemia

23b. Did **tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: W. Bruce Obenshain, M.D.
29c. License number: 035779
29d. Date signed (Month, Day, Year): 2/15/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. Bruce Obenshain, 251 S. Bohemia Ave, Cecilton, Md. 21913

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State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06362

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Louis Dayberry
2. Date of Death (Month, Day, Year): February 14, 1999
3. Time of Death: 2:45 A.M.
4a. Facility Name (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 220-18-4735
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 27, 1926
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: FREDERICK
10c. City, Town or Location: EMMITSBURG
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 16003 B OLD FREDERICK ROAD
10f. Zip Code: 21727
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 1944-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4 or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ELEVATOR ENGINEER
16b. Kind of Business/Industry: MAINTENANCE

17. Father's Name (First, Middle, Last): LEWIS A. DAYBERRY
18. Mother's Name (First, Middle, Maiden Surname): BARBARA MARIE PROCHASKA

19a. Informant's Name/Relationship (Type, Print): MARY A. DAYBERRY / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16003 B OLD FREDERICK ROAD EMMITSBURG, MD 21727

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): NEW ST. JOSEPH'S CEMETERY — Date: FEB 17 1999
20c. Location - City or Town, State: EMMITSBURG, MARYLAND

21. Signature of Funeral Service Licensee: Alan C. Purvis
22. Name and Address of Facility: SKILES FUNERAL HOME, 136 EAST BALTIMORE STREET TANEYTOWN, MD 21787

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Congestive Heart Failure	3wks
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Coronary Artery Disease	11 years
	Due to (or as a consequence of):	
	c. Diabetes mellitus	20 yrs
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular disease
Hypertension
Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D29591
29d. Date signed (Month, Day, Year): 2/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARK RUBIN 201 Thomas Johnson Drive Frederick MD 21702

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06363

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILBUR DALE DAETWYLER
2. Date of Death (Month, Day, Year): FEBRUARY 17,1999
3. Time of Death: 1:00AM
4a. Facility Name (If not institution, give street and number): 8803 KENTUCKY AVENUE
4b. City, Town, or Location of Death: LA PLATA
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 233-50-4397
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 19,1933
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: La Plata
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8803 Kentucky Ave.
10f. Zip Code: 20646
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1952-1956
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electronics Technician
16b. Kind of Business/Industry: Federal Govt.
17. Father's Name (First, Middle, Last): Paul Otto Daetwyler
18. Mother's Name (First, Middle, Maiden Surname): Anna Hildaguard Zumbach Daetwyler
19a. Informant's Name/Relationship (Type, Print): Anna G. Daetwyler/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8803 Kentucky Ave. La Plata,MD 20646
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Trinity Memorial Gar.
Date: 2/20/99
20c. Location - City or Town, State: Waldorf,MD
21. Signature of Funeral Service Licensee: David C. Echols M00945
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME P.A. P.O. BOX 567 LA PLATA,MD 20646

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. MESOTHELIOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Krishan M. Mathur
29c. License number: D28352
29d. Date signed (Month, Day, Year): FEBRUARY 17, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): KRISHAN MATHUR, MD., P.O. BOX 2729, LA PLATA, MD 20646

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06364

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gladys June Eastman
2. Date of Death (Month Day Year): February 13, 1999
3. Time of Death: 7:33 a.m.
4a. Facility Name (If not institution, give street and number): Magnolia Hall Nursing Home
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 316-20-7173
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 21, 1927
9. Birthplace (State or Foreign Country): Indiana

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Millington
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number:
10f. Zip Code: 21651
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postmaster
16b. Kind of Business/Industry: US Postal Service

17. Father's Name (First, Middle, Last): Hiram Joseph Eastman
18. Mother's Name (First, Middle, Maiden Surname): Gladys Lee

19a. Informant's Name/Relationship (Type, Print): Debra Eastman/Sister-in-Law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 145 Hummel Ave, Lemoyne, PA 17043

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Cremation Center, LLC — Date: 2/15/99
20c. Location - City or Town, State: Stevensville, Maryland

21. Signature of Funeral Service Licensee: Kirk A. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. middle cerebral artery thrombosis (L) — 2 month
Due to (or as a consequence of):
b. arteriosclerosis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D16433
29d. Date signed (Month, Day, Year): 2/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wayne D Benjamin MD, Chestertown, Md 21620

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06365

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SEYMOUR EDELMAN
2. Date of Death (Month Day Year): FEBRUARY 16 1999
3. Time of Death: 4:56AM
4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 177 05 3219
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 12, 1914
9. Birthplace (State or Foreign Country): NEW JERSEY

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9115 Glenridge Road
10f. Zip Code: 20910
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PHYSICIST
16b. Kind of Business/Industry: U.S. GOV'T.

17. Father's Name (First, Middle, Last): KALMAN EDELMAN
18. Mother's Name (First, Middle, Maiden Surname): SADIE WIESENBERG

19a. Interment's Name/Relationship (Type, Print): HAZEL EDELMAN/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9115 GLENRIDGE ROAD SILVER SPRING, MARYLAND 20910

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. COMFORT CREMATORY — Date: 2/18/99
20c. Location - City or Town, State: ALEXANDRIA, VIRGINIA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Cardiopulmonary Arrest	1 Hour
Due to (or as a consequence of): b.	Acute Myocardial Infarction	10 Hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Gastrointestinal Bleeding	12 Hours
Due to (or as a consequence of): d.	Hypercoagulable state	12 Hours

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Thrombocytopenia, Pneumonia, Guillian Barre Syndrome, Diabetes Mellitus, Adrenal Insufficiency, Esophagitis

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D051714
29d. Date signed (Month, Day, Year): February, 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JATINDER SINGH SEKHON, 2401 Research Blvd, Suite 102, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: [signature] G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Edelman, Seymour 2/16/99 4:56 Am

30

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06366

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES W. EDWARDS
2. Date of Death (Month, Day, Year): FEB. 16, 1999
3. Time of Death: 9:54 AM
4a. Facility Name (If not Institution, give street and number): WASHINGTON ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-22-5915
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 3, 1914
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: PRINCE GEORGES
10c. City, Town or Location: COLLEGE PARK
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 9014 RHODE ISLAND AVE. #407
10f. Zip Code: 20740
10g. Citizen of What Country? U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PORTER
16b. Kind of Business/Industry: FUNERAL HOME
17. Father's Name (First, Middle, Last): JAMES W. EDWARDS
18. Mother's Name (First, Middle, Maiden Surname): CATHERINE HARRISON
19a. Informant's Name/Relationship (Type, Print): JAMES W. EDWARDS III/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6403 OLD CHAPEL TERR., BOWIE, MD. 20720
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MASODONIA CHURCH CEMETERY — Date: 2/20/99
20c. Location - City or Town, State: ODENTON, MD.
21. Signature of Funeral Service Licensee: W.W. Chambers — M00091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

(B)

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure — Approximate Interval Between Onset and Death: hours
Due to (or as a consequence of):
b. Dehydration, sepsis — days
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D 53411
29d. Date signed (Month, Day, Year): 02/16/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J C Shastri, 3060 Mitchellville Rd #103 Bowie MD 20716

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06367

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sylvia P. Edwards
2. Date of Death (Month, Day, Year): February 17, 1999
3. Time of Death: 9:00 AM
4a. Facility Name (If not institution, give street and number): 2201 Colston Drive, #200
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-18-8236
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 98 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 19, 1900
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2201 Colston Drive, #200
10f. Zip Code: 20910
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bank Teller
16b. Kind of Business/Industry: National Savings and Trust Bank
17. Father's Name (First, Middle, Last): Charles Potter
18. Mother's Name (First, Middle, Maiden Surname): Sarah Elizabeth Snyder
19a. Informant's Name/Relationship (Type, Print): Doris E. Callahan (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906: 15301 Beaverbrook Court, #3-C, Silver Spring, MD
20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: 2/20/99
20c. Location - City or Town, State: Brentwood, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 24 hrs
Due to (or as a consequence of):
b. Sideroblastic Anemia — 6 months
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D09748 MD
29d. Date signed (Month, Day, Year): 2/17/99
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ALAN R. WEINSTOCK MD 10313 Georgia Ave Silver Spring MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06368

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MIRIAM EHRENBERG
2. Date of Death (Month Day Year): FEBUARY 12, 1999
3. Time of Death: 12:05 PM
4a. Facility Name (If not institution, give street and number): LAYHILLCENTER-GENISIS HEALTH CARE
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 042-18-6443
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 82 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 1, 1916
9. Birthplace (State or Foreign Country): CT

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No
10e. Street and Number: 14510 HOMECREST ROAD #3005
10f. Zip Code: 20906
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESCLERK
16b. Kind of Business/Industry: RETAIL
17. Father's Name (First, Middle, Last): HYMAN OTIS ZIERLER
18. Mother's Name (First, Middle, Maiden Surname): TILLIE DORFMAN
19a. Informant's Name/Relationship (Type, Print): GABRIEL NEMETH (SON-IN-LAW)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18608 MEADOWLAND TERR OLNEY, MARYLAND 20832
20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ADATH ISAEL CEMETERY
Date: 2/15/99
20c. Location - City or Town, State: MIDDLETOWN, CT
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPEL INC. 1170 ROCKVILLE PIKE ROCKVILLE MD 20852

To Be Completed by Funeral Director

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. METASTATIC ABENOCARCINOMA OF OVARIES — Approximate Interval Between Onset and Death: ONE MONTH

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D35045
29d. Date signed (Month, Day, Year): FEBRUARY 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PHILIP G. HEIJUM MD 3416 OLANDWOOD CT #204 OLNEY, MD 20832

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06369

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Lamb Eliot, II
2. Date of Death (Month, Day, Year): February 13, 1999
3. Time of Death: 9:08 PM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 213-50-8537
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 7, 1920
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 15100 Interlachen Drive, #521
10f. Zip Code: 20906
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Director of Personnel
16b. Kind of Business/Industry: State Department
17. Father's Name (First, Middle, Last): Thomas Dawes Eliot
18. Mother's Name (First, Middle, Maiden Surname): Sigrid Wijnbladh
19a. Informant's Name/Relationship (Type, Print): Mary Noyes Eliot (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15100 Interlachen Drive, #521, Silver Spring, MD 20906
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 2-15-99
20c. Location - City or Town, State: Beltsville, Maryland
21. Signature of Funeral Service Licensee: Carol A. Dehn
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypercardic Respiratory Failure
Due to (or as a consequence of):
b. Hypotension
Due to (or as a consequence of):
c. Hypoxemia
Due to (or as a consequence of):
d. Ventricular Tachycardia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dilated Cardiomyopathy

Pneumonia

Pulmonary Edema

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Laurel B. Morphew MD
29c. License number: D51908
29d. Date signed (Month, Day, Year): February 14, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David B. Magliaro, M.D., 18111 Prince Philip Drive, Olney, Maryland 20832

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06370

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harry Lawrence Emerson, Jr.
2. Date of Death (Month Day Year): February 12, 1999
3. Time of Death: 4:50 AM
4a. Facility Name (If not institution, give street and number): 4904 Aspen Hill Road
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 346-18-9016
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 28, 1925
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4904 Aspen Hill Road
10f. Zip Code: 20853
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Software Engineer
16b. Kind of Business/Industry: CIA

17. Father's Name (First, Middle, Last): Harry Lawrence Emerson, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Ruth Esther Johnson

19a. Informant's Name/Relationship (Type, Print): Ruth L. Emerson (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4904 Aspen Hill Road, Rockville, Maryland 20853

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 2-13-99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Carol A. Dehn
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Non-Small Cell Lung Cancer — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D29675
29d. Date signed (Month, Day, Year): February 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ralph V. Boccia, M.D., 9707 Medical Center Drive, #300, Rockville, Maryland 20850

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06371

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Norman Harold Evans
2. Date of Death: Month February Day 16 Year 1999
3. Time of Death: 9:00AM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-09-4335
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 11, 1907
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7902 Sleaford Place
10f. Zip Code: 20814
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Patent Attorney
16b. Kind of Business/Industry: United States Government
17. Father's Name (First, Middle, Last): Walter Evans
18. Mother's Name (First, Middle, Maiden Surname): Sara Kalver
19a. Informant's Name/Relationship (Type, Print): Clare McGarry Evans/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7902 Sleaford Place, Bethesda, Maryland 20814
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery — Date: February 19, 1999
20c. Location - City or Town, State: Silver Spring, Maryland
21. Signature of Funeral Service Licensee: Michael E. Hogan — M00846
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ischemic cardiomyopathy

Due to (or as a consequence of): b. rheumatic heart disease with MI

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c. left ventricular dysfunction

Due to (or as a consequence of): d. congestive heart failure.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: S/P anterior MI

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Albert K Lee MD
29c. License number: D31282
29d. Date signed (Month, Day, Year): 2/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Albert K Lee, MD 8218 Wisconsin Ave, #105 Bethesda, MD 20814

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Norman H Evans 2-16-99 9AM

DHMH 16 Rev 6/95

77c

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State of Maryland / Department of Health and Mental Hygiene

99 06372

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA MARIE EVERETT
2. Date of Death (Month, Day, Year): FEB 15 1999
3. Time of Death: 3:10 PM
4a. Facility Name (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 280-22-0511
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 14 1904
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Virginia
10b. County: Fairfax
10c. City, Town or Location: Vienna
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9053 Laurel Hill Court,
10f. Zip Code: 22182
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Entrepreneur
16b. Kind of Business/Industry: Restaurant/Retail
17. Father's Name (First, Middle, Last): Harry Pritchett
18. Mother's Name (First, Middle, Maiden Surname): Katherine Herholz
19a. Informant's Name/Relationship (Type, Print): Ronald H. Everett/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9053 Laurel Hill Ct, Vienna, Va. 22182
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 2/16/99
20c. Location - City or Town, State: Alexandria, Va.
21. Signature of Funeral Service Licensee: Patrick Scott Palmer
22. Name and Address of Facility: MONEY & KING VIENNA FUNERAL HOME, INC. 171 W. Maple Ave., Vienna, Va. 22180

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. MULTIPLE ORGAN FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul D Kane, MD
29c. License number: 194374-1 (NY)
29d. Date signed (Month, Day, Year): 2/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL D. KANE, LCDR, MC, USN
NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06373

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mabel Lee McGinnis Elbourn
2. Date of Death (Month Day Year): February 12, 1999
3. Time of Death: 7:15 a.m.
4a. Facility Name (If not institution, give street and number): 20873 Rock Hall Avenue (Residence)
4b. City, Town, or Location of Death: Rock Hall
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 213-44-0358
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): June 3, 1903
9. Birthplace (State or Foreign Country): Millington, MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Rock Hall
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 20873 Rock Hall Avenue
10f. Zip Code: 21661
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Thomas Nickerson McGinnis
18. Mother's Name (First, Middle, Maiden Surname): Ella Lee Startt
19a. Informant's Name/Relationship (Type, Print): Mabel Lee Elbourn/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20873 Rock Hall Avenue, Rock Hall, MD 21661
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Pauls Cemetery
Date: 2/13/99
20c. Location - City or Town, State: Chestertown, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease 10 years

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Dua to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D17036-MD
29d. Date signed (Month, Day, Year): 2/16/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Susan K. Ross M.D. 516 Washington Ave Chestertown MD 21620

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06374

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH A. EVANS
2. Date of Death: Month 2 Day 15 Year 99
3. Time of Death: 12 NOON
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 220-09-0519
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 11, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 111 Schoolhouse Avenue
10f. Zip Code: 21784
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Heavy Equipment Operator
16b. Kind of Business/Industry: Railroad
17. Father's Name (First, Middle, Last): Sank Evans
18. Mother's Name (First, Middle, Maiden Surname): Jane Woodward
19a. Informant's Name/Relationship (Type, Print): Mrs. Grace P. Evans (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 Schoolhouse Avenue, Sykesville, MD 21784
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorial Park
Date: 2/18/99
20c. Location - City or Town, State: Sykesville, MD
21. Signature of Funeral Service Licensee: Brian L. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. UROSEPSIS — 2.11.99
Due to (or as a consequence of):
b. STROKE
Due to (or as a consequence of):
c. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
d. GENERALISED PSORIASIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
STATUS POST CABG
ATRIAL FIB
DEHYDRATION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: SK BHATIANI
29c. License number: D 15300
29d. Date signed (Month, Day, Year): 2.15.99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SWADESH K BHATIANI 6609 REISTERSTOWN Rd. BALTIMORE MD 21215

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06375

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN A. ELTERMANN
2. Date of Death (Month, Day, Year): February 12, 1999
3. Time of Death: 4:29 am
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: None

Funeral Director

5. Social Security Number: 215-28-8065
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 7, 1930
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6709 Seneca Drive
10f. Zip Code: 21046
10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Healthcare
17. Father's Name (First, Middle, Last): John H. Eltermann
18. Mother's Name (First, Middle, Maiden Surname): Julia Price
19a. Informant's Name/Relationship (Type, Print): Marion A. Eltermann/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6709 Seneca Drive Columbia, Maryland 21046
20a. Method of Disposition: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crest Lawn Cemetery | Date: 2-17-99
20c. Location - City or Town, State: Marriottsville, MD
21. Signature of Funeral Service Licensee: ▶ Sharon A Collins-Witzke
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — Approximate Interval Between Onset and Death: 2 WEEKS.
Due to (or as a consequence of):
b. PNEUMONIA — 3 WEEKS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
MITRAL VALVE DISEASE.
HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
28. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): FEBRUARY 12 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. KAMAL SAWAN JHH 600 N. WOLFE STREET.

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06376

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARLENE PAULA FELDMAN
2. Date of Death: Month FEBRUARY Day 15 Year 1999
3. Time of Death: 0702
4a. Facility Name (If not institution, give street and number): 718 TIFFANY COURT
4b. City, Town, or Location of Death: GAITHERSBURG
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 057.28.8902
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 63 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12.11.1935
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: GAITHERSBURG
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 718 TIFFANY COURT
10f. Zip Code: 20878
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): HARRY ISAACS
18. Mother's Name (First, Middle, Maiden Surname): SALLY "UNKNOWN"

19a. Informant's Name/Relationship (Type, Print): CHARLES FELDMAN/HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 718 TIFFANY CT., GAITHERSBURG, MD 20878

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARKLAWN/MENORAH GARDENS
Date: 2.18.99
20c. Location - City or Town, State: ROCKVILLE, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):
b. DIABETES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
EMPHYSEMA, CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD (OME)
29c. License number: 015236
29d. Date signed (Month, Day, Year): FEBRUARY 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL MARGOLIS MD. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06377

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harold Robert Fisher, Sr.
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 2:20 PM
4a. Facility Name (If not institution, give street and number): Mariner Health of Silver Spring
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 072-03-0980
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Nov. 19, 1909
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Wheaton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2511 Urbana Drive
10f. Zip Code: 20906
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Printer
16b. Kind of Business/Industry: Government Printing Office
17. Father's Name (First, Middle, Last): Willis R. Fisher
18. Mother's Name (First, Middle, Maiden Surname): Jane M. Pike
19a. Informant's Name/Relationship (Type, Print): Harold Robert Fisher, Jr.(son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2511 Urbana Drive, Wheaton, Maryland 20906
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 2-12-99
20c. Location - City or Town, State: Beltsville, Maryland
21. Signature of Funeral Service Licensee: Carol A Dehn
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Aspiration
Due to (or as a consequence of):
c. Dementia
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Edward J. Richards M.D.
29c. License number: D12704
29d. Date signed (Month, Day, Year): February 12, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward J. Richards, M.D., 10301 Georgia Avenue, #203, Silver Spring, MD 20902

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Jerome G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06378

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward L. Folliard
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 7:05 PM
4a. Facility Name (If not institution, give street and number): 2810 Harris Avenue
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-36-9830
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): April 27, 1929
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2810 Harris Avenue
10f. Zip Code: 20902
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Korea
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Telephone Installer
16b. Kind of Business/Industry: Communications

17. Father's Name (First, Middle, Last): Edward L. Folliard
18. Mother's Name (First, Middle, Maiden Surname): Catherine Downey

19a. Informant's Name/Relationship (Type, Print): Marie G. Folliard (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2810 Harris Avenue, Silver Spring, MD20902

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: 2/15/99
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: William L. Byd
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Cirrhosis — Approximate Interval Between Onset and Death: months

Due to (or as a consequence of):
b. Hepatitis C Infection — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Rheumatoid Arthritis

Rectal Cancer remote history

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D15046
29d. Date signed (Month, Day, Year): February 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen J. Newman, M.D., 11500 Old Georgetown Road, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06379

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LESTER L. FRIEDMAN
2. Date of Death (Month Day Year): 02.15.1999
3. Time of Death: 6:45 PM
4e Facility Name *(If not institution, give street and number)*: HEBREW HOME OF GREATER WASHINGTON
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 214.12.1260
6. Sex: 1 ☐ M 2 ☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG. 13, 1922
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: PRINCE GEORGES
10c. City, Town or Location: GREENBELT
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9328 EDMONSTON ROAD #202
10f. Zip Code: 20770
10g. Citizen of What Country?: USA
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALESMAN
16b. Kind of Business/Industry: SHOES
17. Father's Name *(First, Middle, Last)*: NORBERT FRIEDMAN
18. Mother's Name *(First, Middle, Maiden Surname)*: MOLLIE ROSTOV
19e. Informant's Name/Relationship *(Type, Print)*: ROSE FRIEDMAN/WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9328 EDMONSTON RD #202, GREENBELT, MD 20770
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARLINGTON CEM-CHIZUK AMUN — Date: 02.17.99
20c. Location - City or Town, State: BALTIMORE, MD
21. Signature of Funeral Service Licensee: Vernon Simmons
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCT — 12 HOURS
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION, ESSENTIAL
DIABETES MELLITUS TYPE 2
PARKINSONISM - DEMENTIA COMPLEX

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*
29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: D. Patel M.D.
29c. License number: D 18084
29d. Date signed *(Month, Day, Year)*: FEBRUARY 16, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D. D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06380

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wesley Hilton Friend
2. Date of Death (Month Day Year): February 14, 1999
3. Time of Death: 0643
4a. Facility Name (If not institution, give street and number): The Memeorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 214-14-2471
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 5, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Preston
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 22909 Dover Bridge Road
10f. Zip Code: 21655
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: Noble Ford

17. Father's Name (First, Middle, Last): Russell Wesley Friend
18. Mother's Name (First, Middle, Maiden Surname): Viola M.L. Simpson

19a. Informant's Name/Relationship (Type, Print): Hilton Wesley Friend, Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9989 Village Green Dr, Woodstock, Md. 21163

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cem. | Date: 2/18/99
20c. Location - City or Town, State: Beulah, Maryland

21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: Bennie Smith Funeral Home, P.O. Box 1687, Easton, Md. 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Ventricular fibrillation — < 15 min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Asymmetric septal hypertrophy — > 3 yrs.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Essential hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert W. Trever, M.D.
29c. License number: D10938
29d. Date signed (Month, Day, Year): 2-14-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert W. Trever, M.D., 7696 Ocean Gateway, Easton, Md. 21601

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Wesley Friend

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06381

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harriet German
2. Date of Death: Month 02 Day 12 Year 1999
3. Time of Death: 3:30 AM
4a. Facility Name (If not institution, give street and number): HEBREW HOME
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 058-03-7850
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOVEMBER 24, 1917
9. Birthplace (State or Foreign Country): CT

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6121 MONTROSE ROAD
10f. Zip Code: 20852
10g. Citizen of What Country?: UNITED STATES
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): GRANT'S ASSISTANT
16b. Kind of Business/Industry: UNITED STATES GOVERNMENT
17. Father's Name (First, Middle, Last): DAVID WELTFISCH
18. Mother's Name (First, Middle, Maiden Surname): MINNIE COHEN
19a. Informant's Name/Relationship (Type, Print): LEWIS GERMAN (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6123 SWANSEA STREET BETHESDA MD 20817
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING DAVID MEMORIAL GARDEN
Date: 2/15/99
20c. Location - City or Town, State: FALLS CHURCH VA
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPEL INC. 1170 ROCKVILLE PIKE ROCKVILLE MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pulmonary emboli

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. 5min

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: COPD

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gregory A. Compton MD

29c. License number: D24942

29d. Date signed (Month, Day, Year): FEB 12 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): GREGORY A. COMPTON MD 6121 Montrose Rd Rockville, MD

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999

32. Registrar's Signature: Geneva G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06382

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruby Maria Goff
2. Date of Death (Month, Day, Year): Feb. 16, 1999
3. Time of Death: 11:20 AM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 280-30-8096
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 5, 1931
9. Birthplace (State or Foreign Country): McCaskill, AR

Usual Residence of Decedent

10e. State: none
10b. County: none
10c. City, Town or Location: Washington, DC
10d. Inside City Limits: ☒ 1 Yes 2☐ No
10e. Street and Number: 3001 Bladensburg Road
10f. Zip Code: 20018
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Public School

17. Father's Name (First, Middle, Last): Willis Goff
18. Mother's Name (First, Middle, Maiden Surname): Jodie Stuart

19a. Informant's Name/Relationship (Type, Print): Wilma Goble - Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9016 Levelle Drive, Chevy Chase, MD 20815

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Peter's Cemetery
Date: Feb. 21, 1999
20c. Location - City or Town, State: Ozan, AR

21. Signature of Funeral Service Licensee: ▶ Karen W. Pool
22. Name and Address of Facility: Hicks Funeral Home, 407 South Hazel Street, Hope, AR 71801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypernotremia, CVA, Dementia

DM, HTN, PEG tube, Decubitus Ulcers,

CAD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably ☒ 4 Unknown

24a. Was an autopsy performed? 1☐ Yes ☒ 2 No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one)
Hospital: ☒ 1 Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: ☒ 1 Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] M.D.
29c. License number: D0052255
29d. Date signed (Month, Day, Year): February 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Muhammad Ejaz M.D. 8609 2nd Avenue #404B Silver Spring, MD 20910

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06383

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JUDITH GOLDSTEIN
2. Date of Death (Month, Day, Year): FEBRUARY 16, 1999
3. Time of Death: 10:45AM
4a. Facility Name (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 322 09 4356
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 9, 1915
9. Birthplace (State or Foreign Country): ILLINOIS

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 14400 HOMECREST ROAD
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: MONTGOMERY COUNTY PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last): ALEXANDER FINKEL
18. Mother's Name (First, Middle, Maiden Surname): FANNIE FRIEDMAN

19a. Informant's Name/Relationship (Type, Print): HAROLD GOLDSTEIN-HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14400 HOMECREST ROAD, SILVER SPRING, MARYLAND 20906

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MOUNT COMFORT CREMATORY — Date: 2/18/99
20c. Location - City or Town, State: ALEXANDRIA, VIRGINIA

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottemyer
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD. 20852

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE — WEEKS
Due to (or as a consequence of):
b. COPD — YEARS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Steven Lipson MD
29c. License number: D 05885
29d. Date signed (Month, Day, Year): 02/16/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE

12

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06384

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles E. Griggs
2. Date of Death (Month, Day, Year): February 16, 1999
3. Time of Death: 1348
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-28-9918
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): March 12, 1911
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Poolesville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 17212 General Custer Way
10f. Zip Code: 20837
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrical Repairman
16b. Kind of Business/Industry: D.C. Fire Department
17. Father's Name (First, Middle, Last): John Griggs
18. Mother's Name (First, Middle, Maiden Surname): Mamie Olivia Harbin
19a. Informant's Name/Relationship (Type, Print): Claudine V. Griggs (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17212 General Custer Way, Poolesville, MD 20837
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park
Date: 2/20/99
20c. Location - City or Town, State: Rockville, MD
21. Signature of Funeral Service Licensee: Andrew J. Cole
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — Days

Due to (or as a consequence of): b. Pneumonia — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, normal Pressure hydrocephalis, S/P PEG tube

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Muhammad Ejaz MD.
29c. License number: D0052255
29d. Date signed (Month, Day, Year): February 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Muhammad Ejaz M.D. 40 Cottonwood Court Gaithersburg, MD 20910 Suite #404B

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

3

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06385

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Leon Griffin, Sr.
2. Date of Death (Month Day Year): February 13,1999
3. Time of Death: 1520
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 218-40-7352
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 8, 1943
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Annes
10c. City, Town or Location: Grasonville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 337 Wilson Road
10f. Zip Code: 21638
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Thomas H. Pauls Construction/ Excavat

17. Father's Name (First, Middle, Last): George C. Griffin, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Mary Ellen Handy

19a. Informant's Name/Relationship (Type, Print): Marlene G. Griffin, Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 213, Grasonville, Maryland 21638

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gouldtown Cem. Date: 2/20/99
20c. Location - City or Town, State: Gouldtown, Md.

21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Gastric Carcinoma	2 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ David H Smith
29c. License number: D39 887
29d. Date signed (Month, Day, Year): 12/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Smith, M.D., 509 Idlewild Ave, Easton, Md. 21601

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Griffin , Robert

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06386

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Minnie Margaret Grussing
2. Date of Death (Month, Day, Year): February 19, 1999
3. Time of Death: 4:30a.m.
4a. Facility Name *(If not institution, give street and number)*: Chestertown Nursing & Rehabiltation Center
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 219-44-1805
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 25, 1907
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10071 Flatland Road
10f. Zip Code: 21620
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name *(First, Middle, Last)*: Thomas R. Starr
18. Mother's Name *(First, Middle, Maiden Surname)*: Rachel Mellott
19a. Informant's Name/Relationship *(Type, Print)*: William T. G. Grussing/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10071 Flatland Road, Chestertown, MD 21620
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chester Cemetery — Date: 2/23/99
20c. Location - City or Town, State: Chestertown, MD
21. Signature of Funeral Service Licensee: Gary B. Fellows
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) — a. ASCVD arteriosclerosis — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. D. Benjamin MD
29c. License number: D16488
29d. Date signed *(Month, Day, Year)*: 2/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wayne D. Benjamin MD Chestertown MD

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 19 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06387

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES EMORY GREEN SR.
2. Date of Death: Month FEB Day 11 Year 1999
3. Time of Death: 4:57AM
4a. Facility Name (If not institution, give street and number): CARROLL COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 214-16-0534
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 93 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/19/1905
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10e. State: MD.
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2909 BIRD VIEW RD.
10f. Zip Code: 21157
10g. Citizen of What Country? USA.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FARMER
16b. Kind of Business/Industry: AGRICULTURE
17. Father's Name (First, Middle, Last): AARON GREEN
18. Mother's Name (First, Middle, Maiden Surname): ANNA VIRGINIA CONAWAY
19a. Informant's Name/Relationship (Type, Print): HELEN I. GREEN - WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2909 BIRD VIEW RD.,WESTMINSTER, MD. 21157
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): TRINITY LUTHERAN CEM. Date: 2/13/99
20c. Location - City or Town, State: SMALLWOOD, MD.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST.,WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION — 2 days
Due to (or as a consequence of):
b. VASCULAR INSUFFICIENCY
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CARCINOMA OF PROSTATE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] ATTENDING PHYSICIAN
29c. License number: D21155
29d. Date signed (Month, Day, Year): 2/11/99
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Arthur L. RUDO, MD 904 WASHINGTON RD WESTMINSTER, MD 21157

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1999
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06388

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joyce Ann Gore
2. Date of Death: Month Feb Day 05 Year 1999
3. Time of Death: 8:00 AM
4a. Facility Name (If not institution, give street and number): 25850 Brookwood Road
4b. City, Town, or Location of Death: Greensboro
4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 234-48-0264
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 64 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 15 1934
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Greensboro
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 25850 Brookwood Road
10f. Zip Code: 21639
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 12; College (1-4or 5+) 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Editorial Assistant
16b. Kind of Business/Industry: US Naval Academy
17. Father's Name (First, Middle, Last): Ernest Curry
18. Mother's Name (First, Middle, Maiden Surname): Dosha Curry Bias
19a. Informant's Name/Relationship (Type, Print): Lee Gore/ son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25850 Brookwood Road Greensboro, MD 21639
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory Cn
Date: 2/6
20c. Location - City or Town, State: Chester, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fleegle & Helfenbein Funeral Home, PA P.O. Bx 160 Greensboro, MD 21639

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung carcinoma — 1 yr
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D35887
29d. Date signed (Month, Day, Year): 2/5/99.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David H. Smith, MD 509 Idlewild AVe, Easton, MD 21601

State Registrar

31. Date Filed (Month, Day, Year): FEB 09 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06389

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HILLEARY R. HAWKINS SR.
2. Date of Death (Month, Day, Year): FEBRUARY 12,1999
3. Time of Death: 6:15 PM
4a. Facility Name (If not institution, give street and number): 19515 FREDERICK ROAD #170
4b. City, Town, or Location of Death: GERMANTOWN
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 214 14 4293
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 17,1920
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: GERMANTOWN
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 19515 FREDERICK ROAD #170
10f. Zip Code: 20876
10g. Citizen of What Country?: UNITED STATES

To Be Completed by Funeral Director

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+): 0
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COOK
16b. Kind of Business/Industry: RESTAURANT
17. Father's Name (First, Middle, Last): CLAUDE HAWKINS
18. Mother's Name (First, Middle, Maiden Surname): EFFIE HOWES
19a. Informant's Name/Relationship (Type, Print): ELIZABETH I. HAWKINS,WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19515 FREDERICK ROAD,#170,GERMANTOWN,MD.20876
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARKLAWN CEMETERY — Date: 2/16/99
20c. Location - City or Town, State: ROCKVILLE, MD.
21. Signature of Funeral Service Licensee: Muriel H. Barber
22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME, P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

JW

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. SQUAMOUS CARCINOMA RIGHT LUNG — Approximate Interval Between Onset and Death: 3 WKS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CORONARY INSUFFICIENCY,CEREBROVASCULAR INSUFFICIENCY

23b. **Did tobacco use contribute to the cause of death?** 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Millman
29c. License number: D13977
29d. Date signed (Month, Day, Year): FEBRUARY 13,1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. ROBERT MILLMAN,9707 MEDICAL CENTER DRIVE,ROCKVILLE, MD. 20850

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3+1

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Renee G. Sparks

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06390

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PHILLIP E. HEBRON
2. Date of Death (Month, Day, Year): FEB. 10, 1999
3. Time of Death: 9:30 AM
4a. Facility Name (If not institution, give street and number): Mariner Health & Rehab Center
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 214-18-8522
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept.14,1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1111 University Blvd West #1215
10f. Zip Code: 20902
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: Montg. College

17. Father's Name (First, Middle, Last): James E. Hebron
18. Mother's Name (First, Middle, Maiden Surname): Henrietta Johnson

19a. Informant's Name/Relationship (Type, Print): Phyllis Hall (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1111 University Blvd.,W.#1215, Silver Spring MD 20902

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Paul Cemetery
Date: 2/18/99
20c. Location - City or Town, State: Poolesville, MD

21. Signature of Funeral Service Licensee: George R. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 4 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerotic cardiovascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B.H. Rosenbaum, M.D.
29c. License number: D09834
29d. Date signed (Month, Day, Year): 2/12/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): BARRY ROSENBAUM 3720 FARRAGUT AVE KENSINGTON, MD 20895

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Poolesville, MD

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06391

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Caryl Lois Holiber
2. Date of Death: Month Feb. Day 14 Year 1999
3. Time of Death: 1:30 PM
4a. Facility Name (If not institution, give street and number): 6414 Kenhowe Drive
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 072-22-7207
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 21 1928
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6414 Kenhowe Drive
10f. Zip Code: 20817
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Economist
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Peter Sokolower
18. Mother's Name (First, Middle, Maiden Surname): Rose Weiss

19a. Informant's Name/Relationship (Type, Print): Jerome A. Holiber/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6414 Kenhowe Drive, Bethesda, MD 20817

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Judean Memorial Gardens | Date: 2/16/99
20c. Location - City or Town, State: Olney, MD

21. Signature of Funeral Service Licensee: Reginald L. Ne
22. Name and Address of Facility: Takoma Funeral Home, 254 Carroll St. NW Washington, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. OVARIAN CANCER	18 MOS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allen M Mundzac Jr
29c. License number: (DC) 3820
29d. Date signed (Month, Day, Year): 2/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALLEN M MUNDZAC 2141 K ST NW DC 20037

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06392

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Celia Kadish Hollman
2. Date of Death (Month, Day, Year): February 13, 1999
3. Time of Death: 10:40 P.M.
4a. Facility Name (If not institution, give street and number): Manor Care at Kensington Park
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery County

Funeral Director

5. Social Security Number: 022-36-1664
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. If Under 1 Year: Months Days; If Under 24 Hrs.: Hours Min.
8. Date of Birth (Month, Day, Year): October 12,1910
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3616 Littledale Road
10f. Zip Code: 20895
10g. Citizen of What Country? United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Philip Kadish
18. Mother's Name (First, Middle, Maiden Surname): Pauline Cantor

19a. Informant's Name/Relationship (Type, Print): Lawrence D. Hollman /Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6504 Kenhill Road, Bethesda, Maryland 20817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Plymouth Rock Cemetery
Date: February 17, 1999
20c. Location - City or Town, State: Brockton, Massachusetts

21. Signature of Funeral Service Licensee: Howard A Causer
22. Name and Address of Facility: Brezniak Rodman Funeral Home, 1251 Washington Street, West Newton, MA

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Malnutrition — Approximate Interval Between Onset and Death: 3 weeks

Due to (or as a consequence of):
b. Alzheimers disease — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hubert J. Alpert, MD
29c. License number: D 00143 (MD)
29d. Date signed (Month, Day, Year): FEB. 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HUBERT J. ALPERT, MD 8630 FENTON ST. SILVER SPRING, MD 20910

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06393

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen F. Holmes
2. Date of Death (Month, Day, Year): February 13, 1999
3. Time of Death: 1:00 PM
4a. Facility Name (If not institution, give street and number): Prince George's Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-54-1697
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 7, 1908
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 801 Carry Place
10f. Zip Code: 20774
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Char-Woman
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): William Frenzley
18. Mother's Name (First, Middle, Maiden Surname): Rose Roger

19a. Informant's Name/Relationship (Type, Print): Carole Holmes Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 801 Carry Place, Upper Marlboro, Maryland 20774

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery — Date: 2/20/99
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Marvin E. Huth
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9058.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Aortic Valve Stenosis
Due to (or as a consequence of):
b. Degenerative Calcification
Due to (or as a consequence of):
c. Congestive Heart Failure
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Hector K. Collison
29c. License number: D2675
29d. Date signed (Month, Day, Year): February 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hector K. Collison, M.D. 8401 Colesville Road, Silver Spring, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06394

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHONG R. HONG
2. Date of Death (Month, Day, Year): Feb. 12, 1999
3. Time of Death: 3:30 PM
4a. Facility Name (If not institution, give street and number): ADVRNTIST HEALTH CARE
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 214-06-6517
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 13,1914
9. Birthplace (State or Foreign Country): KOREA

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: GAITHERSBURG
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 13529 HUNTING HILL WAY
10f. Zip Code: 20878
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: ASIAN
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: AT HOME
17. Father's Name (First, Middle, Last): MYUNG LEE
18. Mother's Name (First, Middle, Maiden Surname): SOON YANG
19a. Informant's Name/Relationship (Type, Print): YOON HONG/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY — Date: 2/16/99
20c. Location - City or Town, State: SILVER SPRING, MD.
21. Signature of Funeral Service Licensee: ▶ W. N. Chambers MO0091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Dehydration	3 weeks
Due to (or as a consequence of):	b. Prerenal Azotemia	4 days
Due to (or as a consequence of):	c. Viral syndrome	7 days
Due to (or as a consequence of):	d. Dysphagia	10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus Type II
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ K. S. Kim
29c. License number: D18663
29d. Date signed (Month, Day, Year): 2/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KWANG S. KIM, M.D. 50 W. EDMONSTON DR., ROCKVILLE, MD. 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

(B)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3 (3)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06395

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM H. HOPKINS
2. Date of Death (Month, Day, Year): FEB. 13, 1999
3. Time of Death: 8:50 PM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-34-4844
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June30,1929
9. Birthplace (State or Foreign Country): Wash. DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14543 Good Hope Road
10f. Zip Code: 20905
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1948-52
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Micro-film Clerk
16b. Kind of Business/Industry: MSTC Inc.

17. Father's Name (First, Middle, Last): Jerome Hopkins
18. Mother's Name (First, Middle, Maiden Surname): Willie Thompson

19a. Informant's Name/Relationship (Type, Print): Barbara H. Hopkins (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20905): 14543 Good Hope Rd., Silver Spring,,MD

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Good Hope Cemetery
Date: 2/20/99
20c. Location - City or Town, State: Silver Spring,MD

21. Signature of Funeral Service Licensee: George R. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

Physician Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIORESPIRATORY FAILURE	1 DAY
Due to (or as a consequence of):	b. RIGHT BRAIN STEM CEREBELLAR STROKE	1 WEEK
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	YEARS
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Cezar A. Lopez MD
29c. License number: D15405
29d. Date signed (Month, Day, Year): FEBRUARY 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CEZAR A. LOPEZ, MD 18111 PRINCE Phillip Dr. OLNEY, MD 20832

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06396

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stanlie Hughes Howes
2. Date of Death (Month, Day, Year): February 12, 1999
3. Time of Death: 2:35 AM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-56-9991
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 13, 1906
9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Sandy Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1306 Hennessy Terrace
10f. Zip Code: 20860
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): George Francis Hughes
18. Mother's Name (First, Middle, Maiden Surname): Florence LaMar
19a. Informant's Name/Relationship (Type, Print): L. Wilson Howes/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1306 Hennessy Terrace, Sandy Spring, Maryland 20860
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rockville Cemetery — Date: February 16, 1999
20c. Location - City or Town, State: Rockville, Maryland
21. Signature of Funeral Service Licensee: M. H. Pumphrey — M00846
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

(6)

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Compression Fracture L2 and L3

Fracture at Femoral Neck

Comminuted Fracture Rt. Distal Radius and Ulna

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): Feb. 11, 1999
28b. Time of Injury: 8:00 AM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Unknown Found with hand wedged under bed
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Hospital Room-Montgomery General
28f. Location (Street and Number or Rural Route Number, City or Town, State): 18101 Prince Philip Drive, Olney, Maryland

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D15236
29d. Date signed (Month, Day, Year): February 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carl I. Margolis, M.D., 11125 Rockville Pike, Rockville, Maryland 20852

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06397

Georgia Hailstalk

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Georgia E. Hailstalk
2. Date of Death — Month: Feb Day: 18 Year: 1999
3. Time of Death: 1803
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 197-26-6038
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept.1,1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: Trappe
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: White Marsh Road
10f. Zip Code: 21673
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elemantary/Secondary (0-12): 8 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Someone else's home

17. Father's Name (First, Middle, Last): Stephen Potts
18. Mother's Name (First, Middle, Maiden Surname): Georgianna Demby

19a. Informant's Name/Relationship (Type, Print): Dolores King, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4800 Old Trappe Road,Trappe,Maryland 21673

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Paradise Cemetery — Date: 2/23/99
20c. Location - City or Town, State: Trappe,Maryland

21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: Bennie Smith Funeral Home P.O.BOX 1687, Easton,Maryland 21601

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. hemorrhage due to hematoma (subcapsular liver) — Approximate Interval Between Onset and Death: 3 hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ N. Snow
29c. License number: H00533 69
29d. Date signed (Month, Day, Year): 2/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nancy Snow D.O., 219South Washington Street,Easton,Maryland 21601

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06398

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THOMAS WALTER HARPER
2. Date of Death (Month, Day, Year): February 16, 1999
3. Time of Death: 0120
4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 214-16-8385
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 2, 1921
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: St. Michaels
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 101 Miles Ave.
10f. Zip Code: 21663
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII Army
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: Mechanic
16b. Kind of Business/Industry: Automobile
17. Father's Name *(First, Middle, Last)*: William Blunt Harper
18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Willey
19a. Informant's Name/Relationship *(Type, Print)*: Irma S. Harper Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 101 Miles Ave. St. Michaels, Maryland 21663
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Olivet Cemetery — Date: Feb. 19, 1999
20c. Location - City or Town, State: St. Michaels, Maryland
21. Signature of Funeral Service Licensee: Harrison E. Leonard
22. Name and Address of Facility: Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHF — Approximate Interval Between Onset and Death: weeks

Due to (or as a consequence of):

b. Ischemic Cardiomyopathy — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C Rubio MD
29c. License number: D 52856
29d. Date signed *(Month, Day, Year)*: 2/16/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Cynthia Rubio M.D. 219 S. Washington St. Easton, Maryland 21601

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

Thomas Harper

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06399

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sadie Iola Harrison
2. Date of Death: Month Feb, Day 12, Year 1999
3. Time of Death: 11:45PM
4a. Facility Name (If not institution, give street and number): Genesis ElderCare - The Pines
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 216-14-9662
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG.30,1915
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 204 AUGUST STREET
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SEAMSTRESS
16b. Kind of Business/Industry: CLOTHING

17. Father's Name (First, Middle, Last): EDGAR T. FAULKNER
18. Mother's Name (First, Middle, Maiden Surname): ELLA M. STARKEY

19a. Informant's Name/Relationship (Type, Print): MARY E. WALBERT /DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 32013 TUCKAHOE AVENUE, CORDOVA, MD 21625

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN MEMORIAL PARK — Date: 2-16-99
20c. Location - City or Town, State: EASTON, MD

21. Signature of Funeral Service Licensee: ▶ Joseph M. Ostrowski
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. cerebrovascular accident	weeks
Due to (or as a consequence of):	b. Hypertensive arteriosclerosis	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D25750
29d. Date signed (Month, Day, Year): 2/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT SANCHEZ, MD 508 IDLEWILD AVENUE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06400

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Donald Edward Harrington
2. Date of Death (Month Day Year): February 14, 1999
3. Time of Death: 0835
4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 217-52-2352
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 50 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 1 1948
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Greensboro
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 200 Maple Ave.
10f. Zip Code: 21639
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 08 — College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: construction
16b. Kind of Business/Industry: roadway/highway

17. Father's Name *(First, Middle, Last)*: Earl F. Harrington
18. Mother's Name *(First, Middle, Maiden Surname)*: Genevieve Thomas Harrington

19a. Informant's Name/Relationship *(Type, Print)*: Genevieve T. Harrington/ mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 23 Greensboro, Maryland 21639

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greensboro Cemetery — Date: 2/17
20c. Location - City or Town, State: Greensboro, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fleegle & Helfenbein Funeral Home, PA P.O. Box 160 Greensboro, MD 21639

To Be Completed by Funeral Director

Donald Harrington

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Upper Gastro intestinal bleeding — 2 days
Due to (or as a consequence of):
b. Cirrhosis — 10 years
Due to (or as a consequence of):
c. Chronic Alcoholism — 20 years
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D00 51132
29d. Date signed *(Month, Day, Year)*: 2-14-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jorge Abrego, M.D., 609 Daffin Lane, Denton, MD 21629

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 17 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06401

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HERBERT L HUGHES
2. Date of Death (Month, Day, Year): FEBRUARY 14 1999
3. Time of Death: 0113
4a. Facility Name (If not institution, give street and number): KENT & QUEEN ANNE'S HOSPITAL INC
4b. City, Town, or Location of Death: CHESTERTOWN
4c. County of Death: KENT

Funeral Director

5. Social Security Number: 115-14-1738
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 25, 1920
9. Birthplace (State or Foreign Country): Indiana

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Greensboro
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 25245 Calvert Road
10f. Zip Code: 21639
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Operator
16b. Kind of Business/Industry: Univac Sales School

17. Father's Name (First, Middle, Last): Aaron Ethereal Hughes
18. Mother's Name (First, Middle, Maiden Surname): Maude Harriet Hurren

19a. Informant's Name/Relationship (Type, Print): LaRue C. Hughes wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25245 Calvert Road, Greensboro, Maryland 21639

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Capitol Crematory
Date: 2/16/99
20c. Location - City or Town, State: Dover, Delaware

21. Signature of Funeral Service Licensee: Randolph Moore
22. Name and Address of Facility: Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Severe Aspiration Pneumonia — Approximate Interval Between Onset and Death: <24hrs
Due to (or as a consequence of):
b. History of Thoracotomy for Pulmonary Stenosis — ≥2 months
Due to (or as a consequence of):
c. History of Recurrent Pneumonia
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
chronic debilitation, poor nutrition

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D3605-Y
29d. Date signed (Month, Day, Year): 2/15/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 120 Speer Rd Chestertown MD. 21620 — Patrick J. Shanahan, M.D. 120 Speer Road, Chestertown, MD 21620

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Amended line 7, FCHD, KS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06402

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Ray Hartman
2. Date of Death: Month February Day 10 Year 1999
3. Time of Death: 6:02 P.M.
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-36-3995
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 91 ~~90~~ Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 31, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8102 Cambridge Drive
10f. Zip Code: 21704
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Resident Maintenance Engineer
16b. Kind of Business/Industry: State Roads Comm.

17. Father's Name (First, Middle, Last): Joseph Valentine HARTMAN
18. Mother's Name (First, Middle, Maiden Surname): Mary Grace RAY

19a. Informant's Name/Relationship (Type, Print): E. Marlene Hartman/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8102 Cambridge Drive, Frederick, Maryland 21704

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Olivet Cemetery Date Feb 13, 1999
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service License: Keith Lynn Roberson M00706
22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home, 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCARDIAL INFARCTION	2 HOURS
Due to (or as a consequence of):	b. CORONARY ARTERY DISEASE	10 YRS
Due to (or as a consequence of):	c. EMPHYSEMA	10 YRS
Due to (or as a consequence of):	d.	

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Neil Warawdekar MD
29c. License number: D47611
29d. Date signed (Month, Day, Year): 2-11-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NEIL WARAWDEKAR MD 1475 TANEY AVE #204 FREDERICK MD 21702

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1999
32. Registrar's Signature: Geneva B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06403

Amend#26,2/19/99,BMW,Montg.Co per physician

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): OUTDY INTHAVONG
2. Date of Death (Month, Day, Year): FEBRUARY 11, 1999
3. Time of Death: 9:35 PM
4a. Facility Name (If not institution, give street and number): 5501 Hiland Avenue
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 226-39-4318
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 5, 1920
9. Birthplace (State or Foreign Country): Laos

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5501 Hiland Avenue
10f. Zip Code: 20706
10g. Citizen of What Country?: Laos

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Police Officer
16b. Kind of Business/Industry: City Government
17. Father's Name (First, Middle, Last): Inh Inthavong
18. Mother's Name (First, Middle, Maiden Surname): Dam (not available)
19a. Informant's Name/Relationship (Type, Print): James Bannavong/Son in law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5501 Hiland Avenue, Lanham, Maryland 20706
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. — Date: Feb. 14, 1999
20c. Location - City or Town, State: Bethesda, Maryland
21. Signature of Funeral Service Licensee: Ray Sam — M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hepatocellular Carcinoma — yrs
Due to (or as a consequence of):
b. Hepatitis C — yrs
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: ~~4☐ Nursing Home~~ 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D32261
29d. Date signed (Month, Day, Year): FEBRUARY 12, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Richard J. Feldman 9500 Annapolis Rd Lanham MD 20706

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: B. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

3

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06404

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank Girard Jennings
2. Date of Death (Month Day Year): February 11, 1999
3. Time of Death: 5:30 PM
4a. Facility Name (If not institution, give street and number): Manor Care-Potomac
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-05-3316
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 30, 1906
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9904 Woodford Road
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4 or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrical Engineer
16b. Kind of Business/Industry: Railroad and Communications
17. Father's Name (First, Middle, Last): Martin Jennings
18. Mother's Name (First, Middle, Maiden Surname): Mame Brennan
19a. Informant's Name/Relationship (Type, Print): Marie E. Jennings/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9904 Woodford Road. Potomac, Maryland 20854
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park — Date: Feb. 15, 1999
20c. Location - City or Town, State: Rockville, Maryland
21. Signature of Funeral Service Licensee: [signature] M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Pneumonia — Month

Due to (or as a consequence of): Seizure Disorder — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Date of Injury (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D35792

29d. Date signed (Month, Day, Year): February 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Swaroop G. Rao, M.D. 50 West Edmonston Drive, Rockville, Maryland 20852

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06405

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KENNETH W. JOHNSON
2. Date of Death (Month, Day, Year): FEB. 10, 1999
3. Time of Death: 2:45 PM
4a. Facility Name (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL
4b. City, Town, or Location of Death: CLINTON
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 578-34-6837
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 5, 1911
9. Birthplace (State or Foreign Country): MASS.

Usual Residence of Decedent

10a. State: D.C.
10b. County: None
10c. City, Town or Location: Washington D.C.
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1419 19th. St.,S.E.
10f. Zip Code: 20003
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: W.W.II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): -------
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: U.S. Government
17. Father's Name (First, Middle, Last): William P. Johnson
18. Mother's Name (First, Middle, Maiden Surname): Rosa Pulsifer
19a. Informant's Name/Relationship (Type, Print): LOUISE RUIZ /GREAT GRANDDAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8006 Holly Ave., Waldorf, Md. 20601
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. OLIVET CEMETERY
Date: 2/16/99
20c. Location - City or Town, State: WASHINGTON, D.C.
21. Signature of Funeral Service Licensee: W.W. Chambers M00091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES,P.A.,RIVERDALE, MD.20737

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. OBSTRUCTIVE PULMONARY DISEASE — YEARS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D-18545
29d. Date signed (Month, Day, Year): FEB. 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. WISOTSKY MD 12070 OLD LINE CENTER WALDORF MD. 20602

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4+1

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

99-0787-033
B.K.S
LIONEL WILLIAM JURVELIN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06406

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lionel William Jurvelin
2. Date of Death (Month, Day, Year): FEB. 10, 1999
3. Time of Death: 1410 PM
4a. Facility Name (If not institution, give street and number): 6312 20TH AVENUE
4b. City, Town, or Location of Death: HYATTSVILLE
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 213-56-3170
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 48 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 6, 1950
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 6312 20th Avenue
10f. Zip Code: 20782
10g. Citizen of What Country?: USA
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Auto Body Mechanic
16b. Kind of Business/Industry: Garage Repair Owner
17. Father's Name (First, Middle, Last): Eric W. Jurvelin
18. Mother's Name (First, Middle, Maiden Surname): Muriel Jurvelin Bergheim
19a. Informant's Name/Relationship (Type, Print) (mother): Muriel Jurvelin Bonanno
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10207 Folk Street, Silver Spring, MD 20902
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): National Memorial Park
Date: 2/15/99
20c. Location - City or Town, State: Falls Church, VA
21. Signature of Funeral Service Licensee: Steven D Frond
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Contact Gunshot Wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? ☒ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident ☒ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): UNK
28b. Time of Injury: UNK M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject shot self
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): AT HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 6312 20th Ave. 20782

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jonathan Lockie MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): FEB. 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JONATHAN LOCKIE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Received G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06407

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Violet Mae Jacobs
2. Date of Death (Month, Day, Year): February 12, 1999
3. Time of Death: 22:00
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-24-4351
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 9, 1929
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Annes
10c. City, Town or Location: Queen Annes
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 124 Fox Meadow Road
10f. Zip Code: 21657
10g. Citizen of What Country?: USA
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Packer
16b. Kind of Business/Industry: Seafood Plant
17. Father's Name (First, Middle, Last): Percy Jacobs
18. Mother's Name (First, Middle, Maiden Surname): Minnie M. Broadway
19a. Informant's Name/Relationship (Type, Print): Gloria Kellum, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 124 Fox Meadow Road, Queen Annes, Maryland 21657
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sandtown Cemetery
Date: 2/18/99
20c. Location - City or Town, State: Hillsboro, Md.
21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: Bennie Smith Funeral Home P.O. Box 1687, Easton, Md.

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary Arrest
Due to (or as a consequence of):
b. Peripheral Vascular Disease, Gangrene
Due to (or as a consequence of):
c. Severe Extreme. Renal Failure
Due to (or as a consequence of):
d. Sepsis.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ronald C Sukroy
29c. License number: D18480
29d. Date signed (Month, Day, Year): 2/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ronald Sroka M.D., 64 Franklin Street, Annapolis, Md. 21401

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: ▶ Jenna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06408

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Milton L. Jones, SR.
2. Date of Death: Month Feb Day 11 Year 1999
3. Time of Death: 7:30 P.M.
4a. Facility Name (If not institution, give street and number): 5327 Beaver Neck Village Rd
4b. City, Town, or Location of Death: Linkwood
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 213-22-7890
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-6-11
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Linkwood
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5327 Beaver Neck VL. RD
10f. Zip Code: 21853
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Highway Dept.

17. Father's Name (First, Middle, Last): Elbert Jones
18. Mother's Name (First, Middle, Maiden Surname): Estella Conaway

19a. Informant's Name/Relationship (Type, Print): Eva Stewart
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5327 Beaver Neck Village Rd. Linkwood, MD

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Pleasant Cemetery
Date: 2/15/99
20c. Location - City or Town, State: Salem, MD.

21. Signature of Funeral Service Licensee: ▶ Wm A. Prince
22. Name and Address of Facility: Bennie Smith Funeral Home, P.O. Box 1687, Easton, Md. 21601

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 6 months

Immediate Cause (Final disease or condition resulting in death): a. metastatic lung carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: 039749
29d. Date signed (Month, Day, Year): 2/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 503 Dutchmans Lane Easton MD 21601

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06409

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David William Joiner
2. Date of Death (Month, Day, Year): February 14, 1999
3. Time of Death: 5:00a.m.
4a. Facility Name (If not institution, give street and number): Kent & Queen Anne's Hospital
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 218-03-8586
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 28, 1914
9. Birthplace (State or Foreign Country): Rock Hall, MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Rock Hall
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 21259 Haven Road
10f. Zip Code: 21661
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Boat Repair
16b. Kind of Business/Industry: Marine

17. Father's Name (First, Middle, Last): David Joiner
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Minner

19a. Informant's Name/Relationship (Type, Print): Mark Joiner/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8669 Park Drive, Chestertown, MD 21620

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Johns Cemetery
Date: 2/16/99
20c. Location - City or Town, State: Rock Hall, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardio Pulmonary Arrest
Due to (or as a consequence of):
b. Respiratory Failure
Due to (or as a consequence of):
c. Bilateral pneumonia with Effusion
Due to (or as a consequence of):
d. Chronic Obstructive Pulmonary Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atrial and Ventricular Dysrhythmia, Hypertension, Diabetes, Anemia

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): None
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: 823889
29d. Date signed (Month, Day, Year): 2/16/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John C. Ashburne Jr. M.D. 948 Washington Ave, Chestertown Md 21620

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5 + 1

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06410

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John W. Jeffries
2. Date of Death (Month, Day, Year): February 18, 1999
3. Time of Death: 12:25 PM
4a. Facility Name (If not institution, give street and number): VA Maryland Health Care System
4b. City, Town, or Location of Death: Perry Point
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 216-01-9952
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 5 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MAryland
10b. County: Caroline
10c. City, Town or Location: Marydel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 203 Halltown Road
10f. Zip Code: 21649
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): carpenter
16b. Kind of Business/Industry: unknown
17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): Mona Jeffries
19a. Informant's Name/Relationship (Type, Print): Elizabeth Fueller/ guardian
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 264 Maryland, MD 21649
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Eastern Shore Veteran Cm
Date: 2/22
20c. Location - City or Town, State: Hurlock, Maryland
21. Signature of Funeral Service Licensee: Mark C. Fleegle
22. Name and Address of Facility: Fleegle & Helfenbein Funeral Home, PA PO Box 160 Greensboro, MD 21639

To Be Completed by Funeral Director

NAME KNOWN TO PHYSICIAN: JOHN W. JEFFERIES

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 1 Month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Respiratory Failure

Lung Cancer

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D4073
29d. Date signed (Month, Day, Year): February 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): Karithanom Isaac MD
KARITHANOM ISAAC, M.D., VA Maryland Health Care System, Perry Point, MD 21902

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: Bernice B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06411

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Patrick Kane
2. Date of Death (Month, Day, Year): February 13, 1999
3. Time of Death: 6:10 PM
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-46-0971
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 10, 1935
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Montgomery Village
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10005 Desoto Court
10f. Zip Code: 20886
10g. Citizen of What Country?: United States

To Be Completed by Funeral Director

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1957-1961
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attorney
16b. Kind of Business/Industry: Veterans Administration
17. Father's Name (First, Middle, Last): James Patrick Kane, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Ruth McChesney
19a. Informant's Name/Relationship (Type, Print): Dagmar V. Kane / wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10005 Desoto Court, Montgomery Village, MD 20886
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. Date: February 16, 1999
20c. Location - City or Town, State: Bethesda, Maryland
21. Signature of Funeral Service Licensee: Barbara J. McMullen Lawrence M00831
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive pulmonary disease — Approximate Interval Between Onset and Death: years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Thromboembolic disease

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alan S. Chanales MD
29c. License number: 29453
29d. Date signed (Month, Day, Year): February 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALAN S. CHANALES 15225 SHADY GROVE RD ROCKVILLE, MD 20850

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: Geneva G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

KANE

(B)

10+1

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06412

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Anna Keown
2. Date of Death (Month, Day, Year): February 15, 1999
3. Time of Death: 4:15 pm
4a. Facility Name (If not institution, give street and number): Magnolia Hall Nursing Home
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 191-22-6863
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 18, 1910
9. Birthplace (State or Foreign Country): Philadelphia, PA

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 200 Morgnec Road
10f. Zip Code: 21620
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Attendant
16b. Kind of Business/Industry: Union League
17. Father's Name (First, Middle, Last): Charles Wise
18. Mother's Name (First, Middle, Maiden Surname): Margaret KilPatrick
19a. Informant's Name/Relationship (Type, Print): Mrs. Carolyn Norris/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 401 Rolph's Wharf Road, Chestertown, Maryland 21620
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Cross Cemetery/February 18, 1999
20c. Location - City or Town, State: Yeadon, Pennsylvania
21. Signature of Funeral Service Licensee: Gary B. Fellows
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 226 E. Main Street, Cecilton, Maryland 21913

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — Approximate Interval Between Onset and Death: 2 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: JCC Seymour MD
29c. License number: D13824
29d. Date signed (Month, Day, Year): 2-16-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John C. Seymour, 122 Speer Road, Suite 5, Chestertown, MD 21620

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06413

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH ARCHIE KORNAHRENS
2. Date of Death: Month FEB Day 11 Year 1999
3. Time of Death: 12:51 PM
4a. Facility Name (If not Institution, give street and number): NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 251-92-4474
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 41 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 13, 1957
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Eldersburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7096 Macbeth Way
10f. Zip Code: 21784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1976-92
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lieutenant
16b. Kind of Business/Industry: US Navy

17. Father's Name (First, Middle, Last): Carl Kornahrens
18. Mother's Name (First, Middle, Maiden Surname): Glenna Weaver

19a. Informant's Name/Relationship (Type, Print): Mrs. Jean M. Kornahrens (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7096 Macbeth Way Eldersburg, MD 21784

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery
Date: 2/15/99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Brian K. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. AIR EMBOLUS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David A Fernandez MD
29c. License number: 4301060979 (MI)
29d. Date signed (Month, Day, Year): Feb 12 1999

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): DAVID A. FERNANDEZ, LCDR, MC, USN
NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06414

Certificate of Death

Reg. No.

Emma Kraus

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Emma Carolina Kraus
2. Date of Death: Month Feb. Day 9 Year 1999
3. Time of Death: 0932 a.m.
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 052-52-0081
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 25, 1904
9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Denton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 410 Colonial Drive
10f. Zip Code: 21629
10g. Citizen of What Country?: United States

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Caucasian
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home
17. Father's Name (First, Middle, Last): Christian Knorr
18. Mother's Name (First, Middle, Maiden Surname): Unknown
19a. Informant's Name/Relationship (Type, Print): Lorraine K. Arndt Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 North Pintail Drive, Berlin, Maryland 21811
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): The First Presbyterian Church Cemetery of Ewing — Date: 2/12/99
20c. Location - City or Town, State: Trenton, New Jersey
21. Signature of Funeral Service License: Randolph P. Moore
22. Name and Address of Facility: Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Pneumonia — Approximate Interval Between Onset and Death: 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypernatremia, Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: 047492
29d. Date signed (Month, Day, Year): 2/9/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey Denton, MD Po Box 122 Goldsboro MD 21679

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): FEB 10 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06415

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Phyllis W Linthicum
2. Date of Death: Month 02 Day 15 Year 99
3. Time of Death: 1420
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney, MD
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 224-14-0399
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02-25-1919
9. Birthplace (State or Foreign Country): WASHINGTON DC

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15107 INTERLACHEN DR.
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
16b. Kind of Business/Industry: OWN HOME
17. Father's Name (First, Middle, Last): UNOBTAINABLE
18. Mother's Name (First, Middle, Maiden Surname): UNOBTAINALBE
19a. Informant's Name/Relationship (Type, Print): CALVIN LINTHICUM (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2111 BISHOPS CASTLE DR. OLNEY, MD 20832
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FORT LINCOLN CEMETERY
Date: 2-20-99
20c. Location - City or Town, State: BRENTWOOD, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: HINES-RINALDI 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC MELANOMA	1 YEAR
Due to (or as a consequence of):	b. PNEUMONIA	7 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Aheda Ali Khan M.D.
29c. License number: D43323
29d. Date signed (Month, Day, Year): Feb. 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 18111 Prince Philip Drive Suite 111, Olney MD 20832

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06416

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edna Florence Liverett
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 3:55 am
4a. Facility Name *(If not institution, give street and number)*: Rockville Nursing Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-42-0335
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: January 6, 1909
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1322 Crawford Drive
10f. Zip Code: 20851
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name *(First, Middle, Last)*: Samuel Wallace Taylor
18. Mother's Name *(First, Middle, Maiden Surname)*: Lottie Bury
19a. Informant's Name/Relationship *(Type, Print)*: Arlene J. Hawksford/ Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1322 Crawford Drive Rockville, Maryland 20851
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Calvary Churchyard — Date: February 16,1999
20c. Location - City or Town, State: Fletcher, North Carolina
21. Signature of Funeral Service Licensee: [signature] M00335
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — Approximate Interval Between Onset and Death: 1 week

Due to (or as a consequence of):
b. Chronic Right middle lobe syndrome — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? Brain only 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: [signature] MD
29c. License number: D19294
29d. Date signed *(Month, Day, Year)*: February 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Melnick, MD. 911 Russell Avenue Gaithersburg, Maryland 20879-3266

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date Filed *(Month, Day, Year)*: FEB 16 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06417

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HUNG-SIANG LO
2. Date of Death (Month, Day, Year): FEB. 14, 1999
3. Time of Death: 12:25 AM
4a. Facility Name (If not institution, give street and number): MONTGOMERY VILLAGE CARE CENTER
4b. City, Town, or Location of Death: GAITHERSBURG
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 354.76.3054
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10.08.1920
9. Birthplace (State or Foreign Country): CHINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: POTOMAC
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8711 VICTORY LANE
10f. Zip Code: 20854
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: ASIAN
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PROFESSOR
16b. Kind of Business/Industry: EDUCATION
17. Father's Name (First, Middle, Last): SHAW-DAN LO
18. Mother's Name (First, Middle, Maiden Surname): CHEN CHANG
19a. Informant's Name/Relationship (Type, Print): TSI-YU LO/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8711 VICTORY LANE, POTOMAC, MARYLAND 20854
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MOUNT COMFORT CREMATORY — Date: 2.17.99
20c. Location - City or Town, State: ALEXANDRIA, VIRGINIA
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

(b)

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. pneumonia, aspiration	3 weeks
Due to (or as a consequence of):	b. cirrhosis, hepatitis B	10 years
Due to (or as a consequence of):	c. Thrombocytopenia	10 years
Due to (or as a consequence of):	d. thoracic dissecting aneurysm	2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD, PhD
29c. License number: D34969
29d. Date signed (Month, Day, Year): Feb. 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. VICTOR CHIANG, 9707 MEDICAL CENTER DR., ROCKVILLE, MD 20850

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06418

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NATALIE F. LUCHTON
2. Date of Death (Month Day Year): FEBRUARY 12, 1999
3. Time of Death: 1:45PM
4a. Facility Name (If not institution, give street and number): 11409 VIERS MILL ROAD
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578 12 1653
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): APRIL 30 1921
9. Birthplace (State or Foreign Country): WASHINGTONDC

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11409 VIERS MILL ROAD
10f. Zip Code: 20902
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Years or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ECONOMIST
16b. Kind of Business/Industry: US GOV'T.

17. Father's Name (First, Middle, Last): ABRAHAM FRIEDMAN
18. Mother's Name (First, Middle, Maiden Surname): GERTRUDE F. SEIWATZ

19a. Informant's Name/Relationship (Type, Print): ROSALIE GOTTLIEB/SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2607 LOMA STREET SILVER SPRING, MD 20902

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. LEBANON CEMETERY | Date: 2/15/99
20c. Location - City or Town, State: ADELPHI, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive Pulmonary Disease — Approximate Interval Between Onset and Death: years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ruth Kevess Cohen MD
29c. License number: D33159
29d. Date signed (Month, Day, Year): February 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ruth Kevess-Cohen MD 8700 Georgia Ave #400 Silver Spring MD 20910

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06419

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary C. Long
2. Date of Death (Month, Day, Year): February 15 1999
3. Time of Death: 11:07pm
4a. Facility Name (If not institution, give street and number): 7509 Murray Hill Road Apt 525
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 579-38-9090
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 7, 1914
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7509 Murray Hill Road Apt 525
10f. Zip Code: 21046
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Glotzbach
18. Mother's Name (First, Middle, Maiden Surname): May Hanlon

19a. Informant's Name/Relationship (Type, Print): Jo-Ann M. Long/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7509 Murray Hill Road Apt 525 Columbia, MD 21046

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 2-16-99
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: ▶ Sharon A Collins - Witzke
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Congestive heart Failure — 3yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ASCVD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Warren M Ross MD
29c. License number: D 17821
29d. Date signed (Month, Day, Year): February 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WARREN M ROSS MD 4801 Dorsey Hall Drive Ste 201 Ellicott City MD 21042

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06420

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Valerie Catherine Magnanelli
2. Date of Death (Month, Day, Year): February 14, 1999
3. Time of Death: 2:10 AM
4a. Facility Name (If not institution, give street and number): Mariner Health Care at Circle Manor
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-32-8877
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Sept. 29, 1927
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5721 Crawford Drive
10f. Zip Code: 20851
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): James Geiger
18. Mother's Name (First, Middle, Maiden Surname): Margaret Nicholson
19a. Informant's Name/Relationship (Type, Print): John Magnanelli, Jr./Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 23509 Pocahontas Drive, Gaithersburg, Maryland 20882
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: February 18, 1999
20c. Location - City or Town, State: Silver Spring, Maryland
21. Signature of Funeral Service Licensee: [signature] MO1126
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Septicemia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D09834
29d. Date signed (Month, Day, Year): February 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Barry Rosenbaum, M.D. 3720 Farragut Avenue, Kensington, Maryland 20895

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: [signature]

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06421

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLAIRE MARIE MALLOY
2. Date of Death (Month, Day, Year): FEBRUARY 13, 1999
3. Time of Death: 3:45AM
4a. Facility Name *(If not Institution, give street and number)*: HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-32-6606
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEPT. 22, 1927
9. Birthplace *(State or Foreign Country)*: WASHINGTON, DC

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SRPING
10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 12608 EASTBOURNE DR.
10f. Zip Code: 20904
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOME MAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: EDWARD L. SMITH
18. Mother's Name *(First, Middle, Maiden Surname)*: ELLEN CUSHING

19a. Informant's Name/Relationship *(Type, Print)*: JOHN H. MALLOY (SPOUSE)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12608 EASTBOURNE DR. SILVER SPRING, MD 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GATE OF HEAVEN — Date: 2-16-99
20c. Location - City or Town, State: SILVER SPRING, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: HINES-RINALDI 11800 NEWHAMPSHIRE AVENUE SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — 12 hrs.
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Lung Disease, Crohn's Disease, Anemia, Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D31001
29d. Date signed *(Month, Day, Year)*: 2/13/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Stuart Turkeritz, MD — 7500 Greenway Cntr. Dr. #430 Greenbelt, MD. 20770.

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

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Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06422

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie C. Mason
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 9:10 p.m.
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 069-14-0971
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 12, 1916
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3322 Chiswick Court, Apt.#2-H
10f. Zip Code: 20906
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Department Manager
16b. Kind of Business/Industry: Woodward and Lothrop
17. Father's Name (First, Middle, Last): Rudolf Eiter
18. Mother's Name (First, Middle, Maiden Surname): Anna (unavailable)
19a. Informant's Name/Relationship (Type, Print): Robert D. Mason (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6611 Hallam Drive, Upper Marlboro, Maryland 20772
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory — Date: 2/13/99
20c. Location - City or Town, State: Beltsville, Maryland
21. Signature of Funeral Service Licensee: [signature] M00956
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — Approximate Interval Between Onset and Death: 4 days
Due to (or as a consequence of):
b. Pneumonia — 4 days
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: D21615
29d. Date signed (Month, Day, Year): February 12, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marian M. Chung, M.D., 3305 Leisure World Blvd., Silver Spring, MD 20906

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature]

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06423

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLEOLA L. McADAMS
2. Date of Death (Month, Day, Year): FEBRUARY 15, 1999
3. Time of Death: 11:58PM
4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-24-1840
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 14, 1910
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 712 DOWNS DRIVE
10f. Zip Code: 20904
10g. Citizen of What Country?: UNITED STATES
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4 or 5+): 4+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: PUBLIC SCHOOL SYSTEM
17. Father's Name (First, Middle, Last): GRANT BLACKMON
18. Mother's Name (First, Middle, Maiden Surname): CORDELIA LANEY
19a. Informant's Name/Relationship (Type, Print): MAXINE JENKINS/NEICE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 712 DOWNS DRIVE SILVER SPRING, MD 20904
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FT. LINCOLN MAUSOLEUM — Date: 2/22/99
20c. Location - City or Town, State: BRENTWOOD, MD
21. Signature of Funeral Service Licensee: ▶ Sam D. Schwartz
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ENTEROCOLITIS

URINARY TRACT INFECTION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Suresh MD
29c. License number: D32332
29d. Date signed (Month, Day, Year): FEBRUARY 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURESH K. GUPTA, MD 9801 GEORGIA AVE. #220 SILVER SPRING, MD 20902

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06424

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carolyn A. McCoy
2. Date of Death (Month, Day, Year): February 15 1999
3. Time of Death: 22:35
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 243-23-6766
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 36 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 29, 1962
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 124 Duvall Lane, Apt. 302
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): not available
16b. Kind of Business/Industry: not available

17. Father's Name (First, Middle, Last): Kenneth H. McCoy
18. Mother's Name (First, Middle, Maiden Surname): Carmen Palmer

19a. Informant's Name/Relationship (Type, Print): Kenneth H. McCoy / father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18072 South Cypress Drive, Cobb Island, MD 20625

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Montgomery Crematorium, Inc. | Date: February 18, 1999
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Barbara J. McMullen Lawrence M00831
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Deeth
Immediate Cause (Final disease or condition resulting in death)	e. Peri-rectal abscess	DAYS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last	b. Encephalopathy	DAYS
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significent conditiona contributing to death but not resulting in the underlying ceuse given in Part I.: History of alcohol abuse

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end menner es steted. 2☐ Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: A G Rao MD
29c. License number: D35792
29d. Date signed (Month, Day, Year): FEBRUARY, 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SWAROOP RAO, 50, W. EDMONSTON DR, ROCKVILLE, MD

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: Geneva B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

E-F
ITEMS: #10A-C PER INFORMANT G769 3-26-99 WR.

State of Maryland / Department of Health and Mental Hygiene

99 06425

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anne Gilbert Meisler
2. Date of Death: Month February Day 16 Year 1999
3. Time of Death: 3:45 AM
4a. Facility Name (If not institution, give street and number): The Greater Washington Hebrew Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 137-07-6583
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 10, 1911
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: NEW JERSEY ~~Maryland~~
10b. County: CAMDEN ~~Montgomery~~
10c. City, Town or Location: VOORHEES ~~Silver Spring~~
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3 FOXTON COURT ~~11411 Monticello Avenue~~
10f. Zip Code: 08043 ~~20902~~
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: Law Firm
17. Father's Name (First, Middle, Last): Louis Gilbert
18. Mother's Name (First, Middle, Maiden Surname): Becky Kreinetz
19a. Informant's Name/Relationship (Type, Print): Jules Meisler/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11411 Monticello Ave., Silver Spring, MD 20902
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Beth Israel Cemetery — Date: Feb. 17,1999
20c. Location - City or Town, State: Woodbridge, New Jersey
21. Signature of Funeral Service Licensee: ▶ Reginald Vl
22. Name and Address of Facility: Takoma Funeral Home, 234 Carroll Street, NW, Washington, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. INTRA-CEREBRAL HEMORRHAGE	36 Hours
	Due to (or as a consequence of): —	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of): —	
	c.	
	Due to (or as a consequence of): —	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Essential Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D 18084
29d. Date signed (Month, Day, Year): FEBRUARY 16, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): D. D. PATEL M.D. 6121 MONTROSE RD, ROCKVILLE MD 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

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To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06426

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Olivia Merillat
2. Date of Death (Month Day Year): FEBRUARY 12, 1999
3. Time of Death: 12:35 PM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-32-4759
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 3, 1915
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 105 Rockdale Drive
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lab Receptionist
16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): George Cleary
18. Mother's Name (First, Middle, Maiden Surname): Mary McKernan

19a. Informant's Name/Relationship (Type, Print): Stephen Merillat/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11717 River Shore Drive, Dunkirk, MD 20754

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory — Date: 2/14/99
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: James E. Dooley
22. Name and Address of Facility: Francis J. Collins Funeral Home Inc, 500 University Blvd. West, Silver Spring, MD 20901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary arrest
Due to (or as a consequence of):
b. Cardiac arrhythmia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Date of Injury (Month, Day Year)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Susan Cohen
29c. License number: D28267
29d. Date signed (Month, Day, Year): 2/12/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 11402 Allview DR. Beltsville, Md. 20705

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06427

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eli Miller
2. Date of Death (Month, Day, Year): February 12, 1999
3. Time of Death: 8:50 PM
4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 212-03-5084
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 91 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth *(Month, Day, Year)*: November 16, 1907
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1220 East-West Highway, Apt. #1010
10f. Zip Code: 20910
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 4+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrical Contractor
16b. Kind of Business/Industry: Own Business
17. Father's Name *(First, Middle, Last)*: Nathan Miller
18. Mother's Name *(First, Middle, Maiden Surname)*: Bessie M. Rosenthal
19a. Informant's Name/Relationship *(Type, Print)*: Harriet Lebowitz/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 301 Opera Court, Silver Spring, Maryland 20910
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King David Memorial Gdns. Date: Feb. 14, 1999
20c. Location - City or Town, State: Falls Church, Virginia
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Stein Hebrew Memorial Chapel, 234 Carroll Street, NW, Washington, DC 20012

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

(b)

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrest
Due to (or as a consequence of):
b. Resistant hypotension
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation
Renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D 45112
29d. Date signed *(Month, Day, Year)*: 2/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHETAN PATEL WASHINGTON ADVENTIST HOSPITAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(8)

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06428

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gustav Fred Miller
2. Date of Death: Month Feb Day 16 Year 1999
3. Time of Death: 0940
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-38-2992
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 10, 1929
9. Birthplace (State or Foreign Country): WASHINGTON DC

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1609 MAYDALE DR.
10f. Zip Code: 20905
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRINTER PRESSMAN
16b. Kind of Business/Industry: FEDERAL GOVT. PRINTING

17. Father's Name (First, Middle, Last): ARTHUR MILLER
18. Mother's Name (First, Middle, Maiden Surname): TRESA BAUMANN

19a. Informant's Name/Relationship (Type, Print): ALICE G. MILLER (SPOUSE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1609 MAYDALE DR. SILVER SPRING, MD 20905

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): EVERLY FAIRFAX CREMATORY | Date: 2-19-99
20c. Location - City or Town, State: FAIRFAX, VIRGINIA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: HINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RETROPERITONEAL HEMORRHAGE
Due to (or as a consequence of):
b. RUPTURED ABDOMINAL AORTIC ANEURYSM
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D. (OMB)
29c. License number: 015236
29d. Date signed (Month, Day, Year): Feb 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carl I. Margolis MD 11125 Rockville Pike, Rockville Md 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06429

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ralph Elvin Mullendore
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 8:05 AM
4a. Facility Name (If not institution, give street and number): 2012 Lansdowne Way
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-38-3528
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 2, 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2012 Lansdowne Way
10f. Zip Code: 20910
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrical Engineer
16b. Kind of Business/Industry: Census Bureau
17. Father's Name (First, Middle, Last): Harry Martin Mullendore
18. Mother's Name (First, Middle, Maiden Surname): Atha M. Mullendore
19a. Informant's Name/Relationship (Type, Print): Patricia Baczkiewicz (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 318 Larkspur Street, Ridgecrest, California 93555
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 2-12-99
20c. Location - City or Town, State: Beltsville, Maryland
21. Signature of Funeral Service Licensee: Carol A Delon
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Aspiration Pneumonia — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dehydration, Malnutrition, Parkinsonism

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: G. Chablani
29c. License number: D42518
29d. Date signed (Month, Day, Year): February 11, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gul Chablani, M.D., 11119 Rockville Pike, #316, Rockville, Maryland 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

15

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06430

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter Aaron Miller
2. Date of Death (Month, Day, Year): February 14, 1999
3. Time of Death: 6:15 P.M.
4a. Facility Name (If not institution, give street and number): 9233 Fairlee Road
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 215-20-0672
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 26, 1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9233 Fairlee Road
10f. Zip Code: 21620
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farm Laborer
16b. Kind of Business/Industry: Farming
17. Father's Name (First, Middle, Last): Samuel H. Miller
18. Mother's Name (First, Middle, Maiden Surname): Amanda Johnson
19a. Informant's Name/Relationship (Type, Print): Rosemary Dews, Granddaughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9233 Fairlee Road, Chestertown, Md. 21620
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fairlee Cemetery
Date: 2/20/99
20c. Location - City or Town, State: Fairlee, Md.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bennie Smith Funeral Home, P.O. Box 1687, Easton, Maryland 21601

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER — 6 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: 13824
29d. Date signed (Month, Day, Year): 2-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John C. Seymour, M.D., 122 Speer Road, Chestertown, Md. 21620

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06431

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSS MILLER
2. Date of Death (Month, Day, Year): FEB 16 1999
3. Time of Death: 1:32AM
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 217-50-9593
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 15, 1949
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 610 Blankner Road
10f. Zip Code: 21784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Receiver/Fork Lift Operator
16b. Kind of Business/Industry: Food Distribution
17. Father's Name (First, Middle, Last): William C. Miller
18. Mother's Name (First, Middle, Maiden Surname): Virginia Elizabeth Jarvis
19a. Informant's Name/Relationship (Type, Print): Mrs. Lois P. Miller (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 610 Blankner Road Sykesville, MD 21784
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation Serv.
Date: 2/19/99
20c. Location - City or Town, State: Hampstead, MD
21. Signature of Funeral Service Licensee: Brian L. Haight
22. Name and Address of Facility: Haight Funeral Home & Chapel (Box 195) Sykesville, MD 21784 (410)-795-1400

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Malignant Ventricular Arrhythmia — Seconds
Due to (or as a consequence of):
b. Myocardial Ischemia — minutes
Due to (or as a consequence of):
c. Atherosclerotic Cardiovascular Disease — years
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
hypertension, obesity

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No
25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Patryce A. Toye MD Deputy ME
29c. License number: D 31473
29d. Date signed (Month, Day, Year): Feb 16, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRYCE A. TOYE, MD 4565 Hemlock Cove Way Ellicott City MD 21042

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06432

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Mandelia Martin
2. Date of Death (Month Day Year): Feb 11, 1999
3. Time of Death: 1:11 pm
4a. Facility Name (If not institution, give street and number): 3805 Mt. Carmel Road
4b. City, Town, or Location of Death: Upperco
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-20-8356
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Feb 11,1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Upperco
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3805 Mt. Carmel Road
10f. Zip Code: 21155
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Clarence W. Sparks
18. Mother's Name (First, Middle, Maiden Surname): Hazel Hale

19a. Informant's Name/Relationship (Type, Print): Silas P. Martin, husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3805 Mt. Carmel Rd, Upperco, Md 21155

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Salem UM Cemetery
Date: 2/15
20c. Location - City or Town, State: Hampstead, Md

21. Signature of Funeral Service Licensee: ▶ Steven W Eline
22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, Md 21074

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Ventricular fibrillation	instant
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Ischemic cardiomyopathy	5 years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Catherine Magana
29c. License number: D18200
29d. Date signed (Month, Day, Year): 2/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CATHERINE MAGANNA 700 Apple Rd Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06433

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John P. McKeon
2. Date of Death (Month, Day, Year): February 15 1999
3. Time of Death: 2:00am
4a. Facility Name (If not institution, give street and number): Montgomery Village Care & Rehabilitation
4b. City, Town, or Location of Death: Montgomery Village
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 182-24-3004
6. Sex: ☒ 1 M ☐ 2 F
7. Age (In yrs. last birthday): 67 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 26, 1931
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Burtonsville
10d. Inside City Limits: ☐ 1 Yes ☒ 2 No
10e. Street and Number: 3802 Apt 207 Ski Lodge Drive
10f. Zip Code: 20866
10g. Citizen of What Country?: United States
11. Marital Status: ☐ 1 Never Married ☐ 2 Married ☐ 3 Widowed ☒ 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☐ 1 Yes ☒ 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ 1 Yes ☒ 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Automobile
17. Father's Name (First, Middle, Last): John Patrick McKeon
18. Mother's Name (First, Middle, Maiden Surname): Katherine Margaret Kelly
19a. Informant's Name/Relationship (Type, Print): John P. McKeon/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 538 Greencrest Lane Odenton, Maryland 21113
20a. Method of Disposition: ☒ 1 Burial ☐ 2 Cremation ☐ 3 Removal from State ☐ 4 Donation ☐ 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crest Lawn Cemetery — Date: 2-18-99
20c. Location - City or Town, State: Marriottsville, MD
21. Signature of Funeral Service Licensee: ▶ Sherri A Collins-Witzke
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that causad the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Causa (Final disaase or condition resulting in daath):
a. metastatic melanoma (to brain) — Approximate Interval Between Onset and Death: 4 mos
Dua to (or as a consequence of):
b.
Due to (or es a consequence of):
c.
Dua to (or as a consequance of):
d.

Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated evants resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? ☐ 1 Yes ☒ 2 No ☐ 3 Probably ☐ 4 Unknown
24a. Was an autopsy performed? ☐ 1 Yas ☒ 2 No
24b. Were autopsy findings available prior to completion of cause of death? ☐ 1 Yes ☐ 2 No
25. Wes case referred to medical examiner? ☐ 1 Yas ☒ 2 No
26. Place of Death (Check only ona): Hospital: ☐ 1 Inpatient ☐ 2 ER/Outpatient ☐ 3 DOA — Other: ☒ 4 Nursing Homa ☐ 5 Rasidance ☐ 6 Othar (Specify)
27. Manner of Deeth: ☒ 1 Natural ☐ 2 Accident ☐ 3 Suicide ☐ 4 Homicida ☐ 5 Pending investigation ☐ 6 Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Tima of Injury M
28c. Injury at Work? ☐ 1 Yas ☐ 2 No
28d. Describe how Injury occurred
28e. Piece of Injury - At home, farm, streat, tactory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)
29a. Cartifiar (Check only one): ☒ 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to tha cause(s) and menner as stated. ☐ 2 Medical Examiner: On tha basis of examination and/or Investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Alan Pollack
29c. License number: D33443
29d. Date signed (Month, Day, Year): February 16, 1999
30. Nama and addrass of person who completed causa ot daath (Item 23a) (Type, Print): Alan R Pollack, M.D. 809 Viers Mill Rd. Rockville, Md 20851

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signetura: Geneva G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06434

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William R. Mooney, Jr.
2. Date of Death Month: Jan. Day: 31 Year: 1999
3. Time of Death:
4a. Facility Name *(If not institution, give street and number)*: 6036 Oriole Drive
4b. City, Town, or Location of Death: Seaford
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 217-16-9046
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12/15/23
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: DE
10b. County: Dorchester
10c. City, Town or Location: Seaford
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6036 Oriole Drive
10f. Zip Code: 19973
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sewing Factory
16b. Kind of Business/Industry: Manufacturing

17. Father's Name *(First, Middle, Last)*: William R. Mooney, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Gladys Saunders Mooney

19a. Informant's Name/Relationship *(Type, Print)*: Elva Jones Mooney/spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6036 Oriole Drive Seaford, DE 19973

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hill Crest Cemetery
Date: 2/3/99
20c. Location - City or Town, State: Federalsburg, MD

21. Signature of Funeral Service Licensee: ▶ Michael F. Eskow
22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home Federalsburg, Maryland 21632

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End stage Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease
Prostate Carcinoma

23b. **Did tobacco use contribute to the cause of death?** 1 [✓] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Curtis A. Smith DO.
29c. License number: C2-0003304
29d. Date signed *(Month, Day, Year)*: 2/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 314 South Central Ave. Laurel, Delaware 19956 Curtis A. Smith DO.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 1999
32. Registrar's Signature: ▶ Barbara B. Brooks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06435

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elsie Manzella Metzer
2. Date of Death: Month February Day 10 Year 1999
3. Time of Death: 0017
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 195-28-1136
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 24, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Myersville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 12119 Loy Wolfe Road
10f. Zip Code: 21773
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Jacob U. Palmer
18. Mother's Name (First, Middle, Maiden Surname): Tabitha Palmer

19a. Informant's Name/Relationship (Type, Print): Elsie L. Bell / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5623 Mondell Road, Sharpsburg, Maryland 21782

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St.Mark's Lutheran Cemt. | Date: 2-13-99
20c. Location - City or Town, State: Wolfsville, Maryland

21. Signature of Funeral Service Licensee: Patty L. Lukin
22. Name and Address of Facility: 504 Main Street Ricketts Funeral Home Myersville, MD 21773

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	2 Days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Myocardial Infarction	2 Days
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Leo F Kenzakowski MD
29c. License number: D53498
29d. Date signed (Month, Day, Year): 2/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Leo F Kenzakowski, MD 3019 Ventrie Ct Myersville MD 21773

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1999
32. Registrar's Signature: B. Sparks

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06436

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maude Elizabeth McCrossin
2. Date of Death (Month Day Year): February 10, 1999
3. Time of Death: 2:48 P.M.
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-05-5442
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 30, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Monrovia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12095 Stansbury Drive
10f. Zip Code: 21770
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own home
17. Father's Name (First, Middle, Last): Jack Boswell
18. Mother's Name (First, Middle, Maiden Surname): Bessie Merson
19a. Informant's Name/Relationship (Type, Print): Thomas Hugo McCrossin - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12095 Stansbury Drive, Monrovia, Maryland 21770
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Providence Methodist Cem.
Date: 2/13/99
20c. Location - City or Town, State: Kemptown, Maryland
21. Signature of Funeral Service Licensee: Olin L. Molesworth
22. Name and Address of Facility: Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. HYPERKALEMIA — Approximate Interval Between Onset and Death: HOURS
Due to (or as a consequence of):
b. INTRAVASCULAR HEMOLYSIS — HOURS
Due to (or as a consequence of):
c. MESENTERIC INFARCT — 1 day
Due to (or as a consequence of):
d. DIFFUSE ATHEROSCLEROSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D47556
29d. Date signed (Month, Day, Year): 2/10/99
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): WILLIAM H. JOHNSON 187 THOMAS JOHNSON DRIVE FREDERICK MD 21702

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1999
32. Registrar's Signature: B. Sparks

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06437

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN NEAL Sr.
2. Date of Death (Month, Day, Year): Feb 12 1999
3. Time of Death: 0212PM
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 235-38-1767
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 25, 1930
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Md.
10b. County: P.G.
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6103 42nd. Ave. Apt.B102
10f. Zip Code: 20781
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): -----
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician
16b. Kind of Business/Industry: Zarin Electric Co.
17. Father's Name (First, Middle, Last): Jessie Neal
18. Mother's Name (First, Middle, Maiden Surname): Esterline Hall
19a. Informant's Name/Relationship (Type, Print): Stewart A. Neal (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6103 42nd. Ave. Hyattsville, Md. 20781
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Washington Nat'l.Cemetery
Date: 2/19/99
20c. Location - City or Town, State: Suitland, Md.
21. Signature of Funeral Service Licensee: Thomas S. Chambers #670
22. Name and Address of Facility: Chambers Funeral Homes, P.A. 5801 Cleveland Ave. Riverdale, Md. 20737

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lymphoma	months
Due to (or as a consequence of):	b. Diabetes mellitus II	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. hypertension	years
	Due to (or as a consequence of): d. severe anemia	weeks

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dehydration

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D 23998
29d. Date signed (Month, Day, Year): Feb 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PRITAM S. SAINI MD 9101 Cherry Ln #211 Laurel MD 20708

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06438

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lester M. Noel
2. Date of Death (Month, Day, Year): February 13, 1999
3. Time of Death: 3:00 AM
4a. Facility Name (If not institution, give street and number): 11506 College View Drive
4b. City, Town, or Location of Death: Wheaton
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 003-10-8071
6. Sex: 1 ☒ M 2 ☐ F
7. Age (in yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 4, 1914
9. Birthplace (State or Foreign Country): New Hampshire

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Wheaton
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 11506 College View Drive
10f. Zip Code: 20902
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1942-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Alexander Noel
18. Mother's Name (First, Middle, Maiden Surname): Irene Power

19a. Informant's Name/Relationship (Type, Print): Jean B. Noel (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11506 College View Drive, Wheaton, MD 20902

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery | Date: 2/18/99
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: William L Byd
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARREST
Due to (or as a consequence of):
b. ARTERIOSCLEROTIC HEARD DISEASE
Due to (or as a consequence of):
c. ATHEROSCLEROSIS
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CARCINOMA PROSTATE

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward Richards MD
29c. License number: D-12703
29d. Date signed (Month, Day, Year): Feb 13, 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward Richards
10301 GEORGIA AVE SUITE 203 SILVER SPRING MD 20901

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

12+1

99 06439

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anne E. Norris
2. DATE OF DEATH (Month, Day, Year): February 14, 1999
3. TIME OF DEATH: 3:45 P M
4. SOCIAL SECURITY NUMBER: 579-22-4476
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Nov. 19, 1913
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Rockville
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 199 Rollins Avenue, Apt. 215
10f. ZIP CODE: 20852
10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 5+): –
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk
16b. KIND OF BUSINESS/INDUSTRY: Dry Cleaners
17. FATHER'S NAME (First, Middle, Last): William Mayhew
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Mobley
19a. INFORMANT'S NAME (Type/Print): Marion A. Nichols/ Daughter
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 118 Duvall Lane, Apt. 101, Gaithersburg, MD 20877
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parklawn Memorial Park — February 19, 1999
20c. LOCATION — City or Town, State: Rockville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ M00689
22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850-2805

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ruptured abdominal Aortic aneurysm	30 Minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerosis of the abdominal Aorta	weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Generalized Arteriosclerosis	years
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Lewis N Cahill MD
29c. LICENSE NUMBER: D05256
29d. DATE SIGNED (Month, Day, Year): ▶ February 16,1999
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lewis N. Cahill, M.D. 6000 Executive Blvd.,#300, Rockville, Maryland 20852-3803
31. DATE FILED (Month, Day, Year): FEB 19 1999
32. REGISTRAR'S SIGNATURE: Geneva B. Sparks

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5
3

99-811

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06440

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN A NICHOLSON
2. Date of Death: Month FEBRUARY Day 12 Year 1999
3. Time of Death: 1415
4a. Facility Name (If not Institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 150-12-7148
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 20, 1924
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 7142 Lasting Light Way
10f. Zip Code: 21045
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1941-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Business Executive
16b. Kind of Business/Industry: Westinghouse
17. Father's Name (First, Middle, Last): Allen Nicholson
18. Mother's Name (First, Middle, Maiden Surname): Marguerite Eno
19a. Informant's Name/Relationship (Type, Print): Susan N. Meyer/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9216 Dunloggin Road Ellicott City, MD 21042
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 2-16-99
20c. Location - City or Town, State: Catonsville, MD
21. Signature of Funeral Service Licensee: ▶ Donna Collins-Witzke
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Intracranial hemmorhage

Due to (or as a consequence of): b. Fall from horse — 12 HOURS

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

CERTIFICATION APPROVED BY MEDICAL EXAMINER J. Pattani MD.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Valvular Heart Disease with Coumadin Therapy.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): 2/9/99
28b. Time of Injury: Unknown
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: FALL FROM HORSE
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Farm
28f. Location (Street and Number or Rural Route Number, City or Town, State): Howard Co, Md.

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D0053731
29d. Date signed (Month, Day, Year): 2/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES HAAN MD 22 SOUTH GREENE STREET BALTIMORE, MD 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06441

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John R. Nickolson SR.
2. Date of Death: Month FEB Day 16 Year 99
3. Time of Death: 1045 PM
4a. Facility Name (If not institution, give street and number): Lorien Nursing Home
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 705-05-7760
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 4, 1915
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: None
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 253 South Clinton Street
10f. Zip Code: 21224
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner
16b. Kind of Business/Industry: Waste Paper
17. Father's Name (First, Middle, Last): Emory Edward Nickolson
18. Mother's Name (First, Middle, Maiden Surname): Virginia Holliday
19a. Informant's Name/Relationship (Type, Print): Jo Dee Frasco/Granddaughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7765 Chatfield Lane Ellicott City, MD 21043
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 2-18-99
20c. Location - City or Town, State: Catonsville, MD
21. Signature of Funeral Service Licensee: ▶ Sherri A Collins-Witzke
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma of Esophagus — Approximate Interval Between Onset and Death: 2 Months
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Sanjay P. Shah, MD
29c. License number: D0052940
29d. Date signed (Month, Day, Year): FEB 17 99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SANJAY P. SHAH, MD 10805 Hickory Ridge Rd #210, Columbia, MD 21044

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

2

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06442

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Edward O'Connor
2. Date of Death (Month Day Year): Feb. 11, 1999
3. Time of Death: 7:50P.
4a. Facility Name (If not institution, give street and number): Golden Oaks Nursing Home
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 080-01-6741
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan.6,1918
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2XX No
10e. Street and Number: 9420 Royal Path Cove
10f. Zip Code: 20723
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3XX Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1XX Yes 2☐ No If Yes, Give Year or Dates: 1942–1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisory Management Analyst U.S. Government
16b. Kind of Business/Industry
17. Father's Name (First, Middle, Last): William O'Connor
18. Mother's Name (First, Middle, Maiden Surname): Irene Mowbray
19a. Informant's Name/Relationship (Type, Print): Irene Dentinger (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10
20a. Method of Disposition: 1☐ Burial 2XX Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 2/13/1999
20c. Location - City or Town, State: Alexandria, Virginia
21. Signature of Funeral Service Licensee: Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. PROBABLE COLON CANCER — Approximate Interval Between Onset and Death: Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3XX Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes XX No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2XX No

25. Was case referred to medical examiner? 1☐ Yes 2XX No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: XX Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: XX Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): XX 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D25422
29d. Date signed (Month, Day, Year): February 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT MAGGIN, MD. Robert Maggin, M.D. 13952 Baltimore Avenue Laurel, Maryland 20707

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06443

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kwame Osei
2. Date of Death (Month, Day, Year): February 13, 1999
3. Time of Death: 7:57 AM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: None
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours 2, Min. 35
8. Date of Birth (Month, Day, Year): Feb. 13, 1999
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2000 Erie Street, #203
10f. Zip Code: 20783
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): None
16b. Kind of Business/Industry: None
17. Father's Name (First, Middle, Last): Philip Osei
18. Mother's Name (First, Middle, Maiden Surname): Henriett Boateng
19a. Informant's Name/Relationship (Type, Print): Philip Osei (father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2000 Erie Street, #203, Hyattsville, Maryland 20783
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 2-16-99
20c. Location - City or Town, State: Beltsville, Maryland
21. Signature of Funeral Service Licensee: Carol A Dehn
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Extreme Prematurity

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Crump
29c. License number: D45608
29d. Date signed (Month, Day, Year): 02/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. Crump, Divison of Neonatology, 1500 Forest Glen Road, Silver Spring, MD 20910

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06444

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucille Hughett Otto
2. Date of Death (Month Day Year): February 12, 1999
3. Time of Death: 11:45 PM
4a. Facility Name (If not institution, give street and number): 7920 Charleston Court
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 321-28-2218
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 26, 1905
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10a. Street and Number: 7920 Charleston Court
10f. Zip Code: 20817
10g. Citizen of What Country?: United States
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Director of Residence and Student Activities
16b. Kind of Business/Industry: Roosevelt Hospital School of Nursing
17. Father's Name (First, Middle, Last): Charles Robert Hughett
18. Mother's Name (First, Middle, Maiden Surname): Ethel Maude Burner
19a. Informant's Name/Relationship (Type, Print): Nancy Otto Low (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7920 Charleston Court, Bethesda, Maryland 20817
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory — Date: 2-13-99
20c. Location - City or Town, State: Beltsville, Maryland
21. Signature of Funeral Service Licensee: Carol a Dehn
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute Cerebral Vascular Accident — Approximate Interval Between Onset and Death: 2 weeks
Due to (or as a consequence of):
b. Cerebral Vascular Disease — Years
Due to (or as a consequence of):
c. Atrial Fibrillation
Due to (or as a consequence of):
d. Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Albert K Lee MD
29c. License number: D31282
29d. Date signed (Month, Day, Year): February 13, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Albert Lee, M.D., 8218 Wisconsin Avenue, Suite 105, Bethesda, Maryland 20814

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06445

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Phong Outsa
2. Date of Death (Month, Day, Year): February 14, 1999
3. Time of Death: 9:40 AM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-92-6592
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 5, 1911
9. Birthplace (State or Foreign Country): Laos

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 101 Odendhal Avenue #310
10f. Zip Code: 20877
10g. Citizen of What Country?: Laos

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Touy Khetbury
16. Mother's Name (First, Middle, Maiden Surname): Doke (not available)
19a. Informant's Name/Relationship (Type, Print): Samarn Outsa/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 101 Odendhal Ave., #112, Gaithersburg, MD 20877
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. | Date: Feb. 20, 1999
20c. Location - City or Town, State: Bethesda, Maryland
21. Signature of Funeral Service Licensee: Ray Fauk M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION — Approximate Interval Between Onset and Death: 24 Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

ANEMIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D25947
29d. Date signed (Month, Day, Year): February 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene Jackson, MD 3416 Olympian Court, Suite 200, Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06446

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH M. PALEY
2. Date of Death: Month FEBRUARY Day 15 Year 1999
3. Time of Death: 0730
4a. Facility Name (If not institution, give street and number): HEALTH SOUTH OF MARYLAND
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 082 10 7104
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 3, 1917
9. Birthplace (State or Foreign Country): NEW JERSEY

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3108 WELLER ROAD
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLAIMS EXAMINER
16b. Kind of Business/Industry: U.S. DEPT OF LABOR

17. Father's Name (First, Middle, Last): ISSAC MARKOWITZ
18. Mother's Name (First, Middle, Maiden Surname): ANNA ITEL

19a. Informant's Name/Relationship (Type, Print): NITA OLTHOF (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4102 MITSCHER CT, KENSINGTON, MD 20895

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARLINGTON NATIONAL CEMT. | Date: 2-19-1999
20c. Location - City or Town, State: ARLINGTON, VA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPEL, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death) a. INTRACEREBRAL HEMORRHAGE

Due to (or as a consequence of): b. CLOSED HEAD INJURY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SUBDURAL HEMATOMA.

FRACTURE (L) ZYGOMATIC BONE + (R) RADIUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) LETHAL CENTER

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): JANUARY 27, 1999
28b. Time of Injury: EVENING M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: FELL DOWN FLIGHT OF STAIRS
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3108 WHELLER ROAD, SILVER SPRING MD

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D. (OME)
29c. License number: 015236
29d. Date signed (Month, Day, Year): FEBRUARY 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carl I. Margolis, MD 10215 Fernwood Drive, Bethesda, MD 20817

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06447

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vincent A. Pati, Sr.
2. Date of Death (Month, Day, Year): 2-12-99
3. Time of Death: 845pm
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 063-07-1846
6. Sex: XX 1 M 2 F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July24,1914
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1 ☐ Yes 2 XX No
10e. Street and Number: 11328 Melclare Drive
10f. Zip Code: 20705
10g. Citizen of What Country?: United States

11. Maritel Status: 1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 XX No Specify:
14. Rece - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Intelligence
16b. Kind of Business/Industry: United States Govn't.

17. Father's Name (First, Middle, Last): Anthony Pati
18. Mother's Name (First, Middle, Maiden Surname): Carolyn Suriano

19a. Informant's Name/Relationship (Type, Print): Mildred Pati (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): same as #10

20a. Method of Disposition: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: 2/16/1999
20c. Location - City or Town, State: Silver Spring,MD

21. Signature of Funeral Service Licensee: ▶ Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only *one* cause on each line.

Approximate Intervel Between Onset and Death: 2 hours

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration
Due to (or as a consequence of):
b. pulmonary edema
Due to (or es e consequence of):
c. Heart Failure
Due to (or es a consequence of):
d.

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.
lung mass
pneumonia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings eveilable prior to completion of ceuse of death? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es steted. 2 ☐ Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ LWeber MD
29c. License number: D53801
29d. Date signed (Month, Day, Year): 2/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Laura Weber, M.D. 8317 Cherry Lane Laurel, Maryland 20707

State Registrar

31. Dete filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #19a,2/19/99,BMW,Montg.Co.

Certificate of Death

Reg. No. 99 06448

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HIEN DUONG PHAM
2. Date of Death: Month FEBRUARY Day 15 Year 1999
3. Time of Death: 0750
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 213-82-1207
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 14, 1941
9. Birthplace (State or Foreign Country): Vietnam

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 100 Bates Avenue
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Vietnamese
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Economist
16b. Kind of Business/Industry: U. S. Postal Service
17. Father's Name (First, Middle, Last): Quynh Van Pham
18. Mother's Name (First, Middle, Maiden Surname): Dung Duong
19a. Informant's Name/Relationship (Type, Print): Tieu Thanh Luu--wife ~~Tieu Lau Pham, wife~~
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 Bates Avenue, Gaithersburg, MD 20877
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: Feb 18, 1999
20c. Location - City or Town, State: Silver Spring, MD
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Dr., Gaithersburg, MD 20877

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Cerebellar hemorrhagic stroke — 6 days

Due to (or as a consequence of): b.

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Nathan Moskowitz M.D.
29c. License number: D32683
29d. Date signed (Month, Day, Year): February, 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nathan Moskowitz 14812 Physicians Lane Rockville, Maryland 20850

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06449

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TI BOI PHAN
2. Date of Death: Month FEBRUARY Day 14 Year 1999
3. Time of Death: 7:07PM
4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-96-9711
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 56 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 19, 1942
9. Birthplace (State or Foreign Country): VIETNAM

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: WHEATON
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2400 PLYERS MILL ROAD
10f. Zip Code: 20902
10g. Citizen of What Country?: UNITED STATES
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: ASIAN
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: HOME
17. Father's Name (First, Middle, Last): Y PHAN
18. Mother's Name (First, Middle, Maiden Surname): HOA DHI PHAN
19a. Informant's Name/Relationship (Type, Print): SI PHAM/HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2400 PLYERS MILL ROAD WHEATON, MD 20902
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FT. LINCOLN CREMATORY
Date: 2/17/99
20c. Location - City or Town, State: BRENTWOOD, MD
21. Signature of Funeral Service Licensee: ▶ Anthony S. DiMarzo
22. Name and Address of Facility: HINES RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. INTRACEREBRAL HEMORRHAGE
Due to (or as a consequence of):
b. HYPERTENSION
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: D50678
29d. Date signed (Month, Day, Year): FEBRUARY 14, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAJEEU BATRA, MD 10801 LOCKWOOD DRIVE SILVER SPRING, MD 20901

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06450

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dao Poon
2. Date of Death (Month, Day, Year): February 13, 1999
3. Time of Death: 12:25 AM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 256-25-7920
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 14, 1914
9. Birthplace (State or Foreign Country): China

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11907 Parklawn Drive Apt. 101
10f. Zip Code: 20852
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chef
16b. Kind of Business/Industry: Restaurant
17. Father's Name (First, Middle, Last): Unknown Poon
18. Mother's Name (First, Middle, Maiden Surname): Unknown
19a. Informant's Name/Relationship (Type, Print): Yu Poon (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11907 Parklawn Drive #101 Rockville, Maryland 20852
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: 2/20/99
20c. Location - City or Town, State: Silver Spring, Maryland
21. Signature of Funeral Service Licensee: Steven D Strand
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. metastatic pancreatic cancer — Approximate Interval Between Onset and Death: 6 mo
Due to (or as a consequence of):
b. pancreatic cancer — 1 yr
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of Certifier: [signature] MD
29c. License number: D 21531
29d. Date signed (Month, Day, Year): Feb. 13, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): G. Peter Pushkas 11510 Old Georgetown Road, Rockville, MD 20852

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: G. Sparks

Poon, DAO 2/13/99 - 12:25 AM

4

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #11 PER INFORMANT G771 6-2-99 WR.

Certificate of Death

Reg. No. 99 06451

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Linda Lee Rexrode Perryman
2. Date of Death: Month Feb. Day 14 Year 1999
3. Time of Death: 4:15 PM
4a. Facility Name (If not institution, give street and number): 6560 Woodbine Road
4b. City, Town, or Location of Death: Woodbine
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 218-64-5496
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 45 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 11, 1954
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Woodbine
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6560 Woodbine Road
10f. Zip Code: 21797
10g. Citizen of What Country?: United States

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed ~~4☒ Divorced~~
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Social Security Administration
17. Father's Name (First, Middle, Last): Russell B. Rexrode
18. Mother's Name (First, Middle, Maiden Surname): Peggy L. Wagner
19a. Informant's Name/Relationship (Type, Print): Tracie Fontes Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6560 Woodbine Road Woodbine, MD 21797
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crest Lawn Mem. Gardens
Date: 2/17/99
20c. Location - City or Town, State: Marriottsville, MD
21. Signature of Funeral Service Licensee: James B Covey
22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Peritoneal Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Fouad M. Abbas

29c. License number: D 38972

29d. Date signed (Month, Day, Year): 2/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. Fouad M. Abbas 2411 W. Belvedere Ave Baltimore, MD 21215

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 06452

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY CATHERINE RICE
2. Date of Death (Month, Day, Year): February 17, 1999
3. Time of Death: 9:45 AM
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 217-18-2489
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): October 26, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: Indian Head
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 30 Circle Ave.
10f. Zip Code: 20640
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home
17. Father's Name (First, Middle, Last): Charles Harry Spalding
18. Mother's Name (First, Middle, Maiden Surname): Mary Violet Tippett Spalding
19a. Informant's Name/Relationship (Type, Print): Francis C. Rice/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 30 Circle Ave. Indian Head, MD 20640
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Ignatius Cem.
Date: 2/20/99
20c. Location - City or Town, State: Port Tobacco, MD
21. Signature of Funeral Service Licensee: David C. Echols 1100445
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME P.A. P.O. BOX 567 LA PLATA, MD 20646

To Be Completed by Funeral Director

Mary Rice

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Aortic Stenosis.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: B-25992
29d. Date signed (Month, Day, Year): 2/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Khadar Baig, MD
6620 Crain HWY, PO Box 190
La Plata, Maryland 20646

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06453

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Peck Risser
2. Date of Death (Month, Day, Year): Feb 17 1999
3. Time of Death: 09:50pm
4e. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 226-40-9627
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): JULY 26, 1927
9. Birthplace (State or Foreign Country): INDIANA

Usual Residence of Decedent

10e. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: BETHESDA
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 7530 CAYUGA AVENUE
10f. Zip Code: 20817
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4 YEARS
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last): ROBERT ROY PECK
18. Mother's Name (First, Middle, Maiden Surname): SELMA STEGMANN

19e. Informant's Name/Relationship (Type, Print): JAMES BRUCE RISSER(HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7530 CAYUGA AVE,BETHESDA,MD.20817

20e. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GEORGETOWN MED.SCH.
Date: 2/17/99
20c. Location - City or Town, State: WASHINGTON, D.C.

21. Signature of Funeral Service Licensee: Terry [illegible]
22. Name and Address of Facility: AUSTIN ROYSTER FUNERAL HOME 3821 14TH STREET N.W.,WASH,DC.20011

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Respiratory Failure

Due to (or as a consequence of):
b. acute exacerbation copd — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. copd — years

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Roy Fried MD
29c. License number: D34590
29d. Date signed (Month, Day, Year): Feb 18 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Roy Fried MD 1500 Forest Glen Rd Silver Spring Md 20910

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06454

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARIE H. ROBINSON
2. Date of Death (Month, Day, Year): FEBRUARY 13, 1999
3. Time of Death: 3 30 AM
4a. Facility Name (If not institution, give street and number): Manor Care Silver Spring
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-84-4652
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 20, 1906
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: D.C.
10b. County: None
10c. City, Town or Location: Washington
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1800 Randolph St., N.E.
10f. Zip Code: 20018
10g. Citizen of What Country?: United States

To Be Completed by Funeral Director

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Colored
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): William Henry Harris
18. Mother's Name (First, Middle, Maiden Surname): Jane Badger
19a. Interment's Name/Relationship (Type, Print): Ellen R. David
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1101 S. Arlington Ridge Rd.#217,Arlington,Va.22202
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Memorial Cemetery — Date: 2/18/99
20c. Location - City or Town, State: Suitland, Md.
21. Signature of Funeral Service Licensee: Lynne McGuire
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, D.C. 20012

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. SEPSIS	DAYS
Due to (or as a consequence of):	b. PNEUMONIA	WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of):	c. CONGESTIVE HEART FAILURE	WEEKS
Due to (or as a consequence of):	d. CORONARY ARTERY DISEASE	YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D25422
29d. Date signed (Month, Day, Year): FEBRUARY 13, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ROBERT MAGGIN, MD 13952 BALTIMORE AVE LAUREL, MARYLAND 20707

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06455

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Josephine Rust
2. Date of Death (Month, Day, Year): February 12, 1999
3. Time of Death: 12:25 PM
4a. Facility Name (If not institution, give street and number): Salisbury Center: Genesis ElderCare
4b. City, Town, or Location of Death: Salisbury, MD
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 176-03-9853
6. Sex: 1 ☐ M ☒ F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 23, 1914
9. Birthplace (State or Foreign Country): Landsdowne, PA

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wycomico
10c. City, Town or Location: Tyaskin
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No
10e. Street and Number: 3945 Jesterville Road
10f. Zip Code: 21865
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dietian
16b. Kind of Business/Industry: Food Processing Co.

17. Father's Name (First, Middle, Last): Joseph H. Bowers
18. Mother's Name (First, Middle, Maiden Surname): Nadine Lytle

19a. Informant's Name/Relationship (Type, Print): Nadine Coar Pusey/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3945 Jesterville Road, Tyaskin, MD 21865

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Pauls Cemetery — Date: 2/18/99
20c. Location - City or Town, State: Chestertown, MD

21. Signature of Funeral Service Licensee: Kirk A. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. COPD — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Allen, M.D.
29c. License number: D24168
29d. Date signed (Month, Day, Year): 2/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert B. Allen, M.D. 100 Power St. Salisbury, MD 21804

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Renee G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06456

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Pearl Rill
2. Date of Death (Month Day Year): Feb 14, 1999
3. Time of Death: 11:10 pm
4a. Facility Name (If not institution, give street and number): Long View Nursing Home
4b. City, Town, or Location of Death: Manchester
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 220-01-6359
6. Sex: 1 ☐ M 2 ☒ F
7. Age (in yrs. last birthday): 88 Yrs. | If Under 1 Year: Months Days | If Under 24 Hrs.: Hours Min.
8. Date of Birth (Month, Day, Year): Aug 9,1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Manchester
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3611 Maple Grove Road
10f. Zip Code: 21102
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Presser
16b. Kind of Business/Industry: Sewing Factory
17. Father's Name (First, Middle, Last): Harry Bowman
18. Mother's Name (First, Middle, Maiden Surname): Mary Shipley
19a. Informant's Name/Relationship (Type, Print): Joyce Murray, daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3611 Maple Grove Rd, Manchester, MD 21102
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Wesley Cemetery
Date: 2/18
20c. Location - City or Town, State: Hampstead, MD
21. Signature of Funeral Service Licensee: ▶ Steven W Eline
22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, Md 21074

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Spinal Cord Tumor — yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: 33165
29d. Date signed (Month, Day, Year): 2/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Stoffer 2111 Hanover Pike Hampstead MD 21074

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06457

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carlton H. Rigler
2. Date of Death (Month, Day, Year): Feb. 2 1999
3. Time of Death: 6:15 p.m.
4a. Facility Name (If not institution, give street and number): Citizens Nursing Home
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-14-7208
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 17, 1921
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10e. State: MD.
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 415 S. Market Street
10f. Zip Code: 21078
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Store Owner
16b. Kind of Business/Industry: Furniture
17. Father's Name (First, Middle, Last): William H. Rigler
18. Mother's Name (First, Middle, Maiden Surname): Winnie Donaldson
19a. Informant's Name/Relationship (Type/Print): Nettie Rigler, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1500 Barrett St., Havre de Grace, MD 21078
20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Deer Park Cemetery — Date: 2-6-99
20c. Location - City or Town, State: Westminster, MD.
21. Signature of Funeral Service Licensee: ▶ John K Ayres
22. Name and Address of Facility: Pritts Funeral Home & Chapel, P.A. 412 Washington Road Westminster, MD. 21157

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

hypertension
cerebrovascular accident;
azotemia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Hong J. Kim, M.D.
29c. License number: D37364
29d. Date signed (Month, Day, Year): February 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 13 Walnut Lane, Aberdeen, Maryland 21001 — Hong J. Kim, M.D.

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amended Items 8 & 20c, per F.D. 2/16/99, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06458

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Merton Augustus Rhinecker
2. Date of Death (Month, Day, Year): February 12 1999
3. Time of Death: 3:15 AM
4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 218-30-4215
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 73 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: ~~Feb 3, 1999~~ Feb 3, 1926
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Mount Airy
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 703 Park Ave.
10f. Zip Code: 21771
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance Supervisor
16b. Kind of Business/Industry: Montgomery Co. Schools

17. Father's Name *(First, Middle, Last)*: Edgar A. Rhinecker
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary E. Myers

19a. Informant's Name/Relationship *(Type, Print)*: Betty Marie Rhinecker (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 703 Park Ave. Mount Airy, MD 21771

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Prospect Cemetery — Date: 2/15/99
20c. Location - City or Town, State: Mount Airy, MD ~~Mount Airy, MD~~

21. Signature of Funeral Service Licensee: ▶ James B Covey
22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Malignant Melanoma — 1 YEAR
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D41866
29d. Date signed *(Month, Day, Year)*: FEBRUARY 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KANAN HUDHU D.MD 801 TOLLHOUSE AVENUE FREDERICK, MD 21701

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 16 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

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Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06459

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Harrison Rippeon
2. Date of Death (Month, Day, Year): Feb. 12, 1999
3. Time of Death: 12:20 AM
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-20-3176
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 5, 1926
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Frederick
10c. City, Town or Location: Myersville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3633A Brethren Church Rd.
10f. Zip Code: 21773
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: W. W. II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Pharmacy
17. Father's Name (First, Middle, Last): Lester H. Rippeon
18. Mother's Name (First, Middle, Maiden Surname): Annie Crum
19a. Informant's Name/Relationship (Type, Print): Kenneth Rippeon (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9903 Mt. Tabor Rd., Myersville, Md. 21773
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery — Date: 2/15
20c. Location - City or Town, State: Frederick, Md.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Donald B. Thompson Funeral Home, 31 E. Main St., Middletown, Md. 21769

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — Approximate Interval Between Onset and Death: 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD
29c. License number: D0053498
29d. Date signed (Month, Day, Year): 2/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Leo F Kenzakowski, MD 3019 Ventrie Ct Myersville, MD 21773

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06460

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Preston Leroy Sattlethight
2. Date of Death (Month, Day, Year): Feb. 9, 1999
3. Time of Death: 8:10 PM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-44-4383
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 64 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 29, 1934
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 8604 Flower Avenue, #1
10f. Zip Code: 20912
10g. Citizen of What Country?: United States
11. Marital Status: Unavailable — 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter
16b. Kind of Business/Industry: Self Employed
17. Father's Name (First, Middle, Last): Unavailable
18. Mother's Name (First, Middle, Maiden Surname): Unavailable
19a. Informant's Name/Relationship (Type, Print): Dorothy W. Fincher (friend)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8604 Flower Avenue, #301, Takoma Park, MD 20912
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 2-13-99
20c. Location - City or Town, State: Beltsville, Maryland
21. Signature of Funeral Service Licensee: Carol A Dehn
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma Lung — Approximate Interval Between Onset and Death: Years.
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Non insulin dependent diabetes
Gastritis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D 53411
29d. Date signed (Month, Day, Year): 2/10/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JC Shesadri 3060 Mitchellville Rd #103 Bowie MD 20716

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: G. Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06461

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANDREW JACKSON SCHROEDER
2. Date of Death (Month Day Year): FEB 15 1999
3. Time of Death: 11:05 PM
4a. Facility Name (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 461-01-8708
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 28, 1915
9. Birthplace (State or Foreign Country): Texas

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 14613 Deerhurst Terrace
10f. Zip Code: 20906
10g. Citizen of What Country? USA

11. Maritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-62
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electronics Engineer
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Andrew Schroeder
18. Mother's Name (First, Middle, Maiden Surname): Mary Gebauer

19a. Informant's Name/Relationship (Type, Print): Jean L. Schroeder (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14613 Deerhurst Terrace, Silver Spring, MD 20906

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory — Date: 2/17/99
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Eric A. Scerbo
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination end/or Investigation, In my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Paul D Kane, MD
29c. License number: 194374-1 (NY)
29d. Date signed (Month, Day, Year): 2/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL D. KANE, LCDR, MC, USN — NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Geneva B. Sparks

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06462

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RALPH SHAUGHNESSY
2. Date of Death: Month FEBRUARY Day 16 Year 1999
3. Time of Death: 12:10 PM
4a. Facility Name (If not institution, give street and number): SHARON NURSING HOME
4b. City, Town, or Location of Death: SANDY SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-28-2291
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 5, 1910
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 4435 Hallet Street
10f. Zip Code: 20853
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrator
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Walter Shaughnessy
18. Mother's Name (First, Middle, Maiden Surname): Louise Unknown

19a. Informant's Name/Relationship (Type, Print): Kevin M. Shaughnessy (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4435 Hallet Street, Rockville, MD 20853

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory — Date: 2/19/99
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Eric S. Scerbo
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE TUBULAR NECROSIS	WEEKS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. CHRONIC RENAL INSUFFICIENCY	YEARS
Due to (or as a consequence of):		
	c. HYPERTENSION	YEARS
Due to (or as a consequence of):		
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: SICK SINUS SYNDROME; ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ATTENDING PHYSICIAN
29c. License number: D42046
29d. Date signed (Month, Day, Year): FEBRUARY 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GRACE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING MARYLAND 20860

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06463

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSE CLAIRE SHECHTMAN
2. Date of Death (Month, Day, Year): FEBRUARY 16, 1999
3. Time of Death: 11:50 AM
4a. Facility Name (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 412-18-3418
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): NOVEMBER 4, 1921
9. Birthplace (State or Foreign Country): TN

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 15101 INTERLACHEN DRIVE #810
10f. Zip Code: 20906
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LEGAL RESEARCHER
16b. Kind of Business/Industry: ADVERTISING
17. Father's Name (First, Middle, Last): MAX SHECHTMAN
18. Mother's Name (First, Middle, Maiden Surname): ANNIE MANDELEIL
19a. Informant's Name/Relationship (Type, Print): BENA EHRLICH (SISTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5120 ORDORA DRIVE CORAL GABLES FLORIDA 33146
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): JUDEAN MEMORIAL GARDENS
Date: 2/18/99
20c. Location - City or Town, State: OLNEY MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPEL 1170 ROCKVILLE PIKE ROCKVILLE MD 20852

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 6hrs

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Lymphoma, Diffuse Sclerosing
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D24942
29d. Date signed (Month, Day, Year): Feb 16 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GREGORY A. COMPTON MD 6121 Montrose Rd Rockville, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: [signature] G. Sparks

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State of Maryland / Department of Health and Mental Hygiene

ITEMS: #1, PER MD #17 PER F.H. G769 3-5-99 WR.

Certificate of Death

Reg. No. 99 06464

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Victoria SCHUCK ~~Shuck~~
2. Date of Death (Month, Day, Year): February 15, 1999
3. Time of Death: 7:30 PM
4a. Facility Name (If not institution, give street and number): Manor Care Chevy Chase
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 015-26-0963
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): March 16, 1909
9. Birthplace (State or Foreign Country): Oklahoma

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8700 Jones Mill Road
10f. Zip Code: 20815
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Professor
16b. Kind of Business/Industry: College

17. Father's Name (First, Middle, Last): Anthony B. ~~Shuck~~ SCHUCK
18. Mother's Name (First, Middle, Maiden Surname): Anna Mary Preebe

19a. Informant's Name/Relationship (Type, Print): Renee I. Fox (guardian)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1725 K Street, #1202, NW, Washington, DC 20006

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory | Date: 2-17-99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Carol A Dehn
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Dysphagia — 1 Week
Due to (or as a consequence of):
b. Dementia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Depression with psychosis, Vit. B12 Deficiency, Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ellen M Pinholt
29c. License number: D 51015
29d. Date signed (Month, Day, Year): February 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ellen Pinholt, M.D., 5530 Wisconsin Avenue, Suite 1045, Chevy Chase, Maryland 20815

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06465

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): MARIO SIERRA
2. Date of Death: Month FEBRUARY Day 15 Year 1999
3. Time of Death: 0831
4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY
5. Social Security Number: 265-74-7010
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 30, 1932
9. Birthplace (State or Foreign Country): CUBA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 12132 VIERS MILL ROAD
10f. Zip Code: 20906
10g. Citizen of What Country?: UNITED STATES
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] Yes 2 [ ] No Specify: CUBAN
14. Race - American Indian, Black, White, etc. Specify: HISPANIC
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 4+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: MAINTENANCE
17. Father's Name (First, Middle, Last): MIGUEL SIERRA
18. Mother's Name (First, Middle, Maiden Surname): JUANA CUEVAS
19a. Informant's Name/Relationship (Type, Print): MARTIN SIERRA/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12132 VIERS MILL ROAD SILVER SPRING, MD 20906
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FT. LINCOLN CREMATORY — Date: 2/19/99
20c. Location - City or Town, State: BRENTWOOD, MD
21. Signature of Funeral Service Licensee: Anthony S. Di Mag
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD (OMB)
29c. License number: 015236
29d. Date signed (Month, Day, Year): FEBRUARY 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL I. MARGOLIS, M.D. (OMB) 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06466

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edith Simon
2. Date of Death (Month, Day, Year): February 8, 1999
3. Time of Death: 4:37 PM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-56-1136
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 26, 1914
9. Birthplace (State or Foreign Country): Hungary

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 15300 Beaverbrook
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Saleslady
16b. Kind of Business/Industry: Watch Repair

17. Father's Name (First, Middle, Last): Unavailable
18. Mother's Name (First, Middle, Maiden Surname): (Unavailable) Sebok

19a. Informant's Name/Relationship (Type, Print): Joan A. Barsky (Attorney-In-Fact)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3752 South Leisure World Blvd, Silver Spring, MD 20906

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory — Date: 2-12-99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Carol A Delon
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Bilateral Pneumonia — days
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marian M. Chung MD
29c. License number: D21615
29d. Date signed (Month, Day, Year): February 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marian M. Chung, M.D., 3305 North Leisure World Blvd., Silver Spring, MD 20906

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Donna G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06467

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Photini Gregorios Skenderis
2. Date of Death (Month, Day, Year): February 14, 1999
3. Time of Death: 1920
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-80-8332
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 21, 1904
9. Birthplace (State or Foreign Country): Greece

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 13709 Beret Place
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Serafimi Canavos
18. Mother's Name (First, Middle, Maiden Surname): Vasiliki Papoulia

19a. Informant's Name/Relationship (Type, Print): Metaxia Dousikos (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13709 Beret Place, Silver Spring, MD 20906

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery — Date: 2/17/99
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: J. Ken Stiles
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute and massive heart attack	14 days
Due to (or as a consequence of): b.	Sepsis	14 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	pneumonia	14 days
Due to (or as a consequence of): d.	Acute Respiratory distress	14 days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: N.A.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): N.A.
28b. Time of Injury: N.A. M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No: N.A.
28d. Describe how injury occurred: N.A.
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N.A.
28f. Location (Street and Number or Rural Route Number, City or Town, State): N.A.

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Byoung K. Lee, M.D.
29c. License number: D0021033
29d. Date signed (Month, Day, Year): February 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Byoung K. Lee, M.D. 13000 Georgia Avenue, Silver Spring MD 20906

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

SLAUGHTER ELIZABETH

Certificate of Death

99 06168 2/11/99 8 20 AM

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Jean Slaughter
2. Date of Death (Month, Day, Year): Feb. 11, 1999
3. Time of Death: 8:20AM
4a. Facility Name (If not institution, give street and number): Manor Care
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-60-6197
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Oct. 10, 1910
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 5480 Wisconsin Ave.
10f. Zip Code: 20815
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Book Keeper
16b. Kind of Business/Industry: U.S. Government
17. Father's Name (First, Middle, Last): William Coleman Slaughter
18. Mother's Name (First, Middle, Maiden Surname): Alice Crew
19a. Informant's Name/Relationship (Type, Print): Lillian O. Owens- Cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 Francis Rd., Ashland, VA 23005
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore-Washington Crematory
Date: 2/15/99
20c. Location - City or Town, State: Laurel, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Joseph Gawler's Sons INC, 5130 Wisconsin AVe. NW., Washington, DC 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Heart Disease	5 Years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aortic Stenosis

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ellen M Pinhol MD
29c. License number: D51015
29d. Date signed (Month, Day, Year): Feb. 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ellen Pinholt, MD 5530 Wisconsin Ave. #1045, Chevy Chase, MD 20815

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Geneva G. Sparks

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06469

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sylvia Carrigan Smith
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 9:25 AM
4a. Facility Name (If not institution, give street and number): Brooke Grove Nusring Home
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-46-6764
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 1, 1904
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14400 Homecrest Road
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): William Thomas Carrigan
18. Mother's Name (First, Middle, Maiden Surname): Anita Blanche Hardesty
19a. Informant's Name/Relationship (Type, Print): Joanne Culler (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3523 Olympic Street, Silver Spring, MD 20906
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery — Date: 2/15/99
20c. Location - City or Town, State: Brentwood, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. CONGESTIVE HEART FAILURE — Approximate Interval Between Onset and Death: months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION
TRANSIENT ISCHEMIC ATTACKS.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No
25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D38457
29d. Date signed (Month, Day, Year): FEBRUARY 12, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NAKUL GOYAL MD, 18111 PRINCE PHILIP DR, OLNEY, MD 20832

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 99 06470

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Smith
2. Date of Death: Month Feb Day 16 Year 1999
3. Time of Death: 5:30 PM
4a. Facility Name (If not institution, give street and number): Howard Co. General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 218-20-0368
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 1, 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: ☒ Yes 2 ☐ No
10e. Street and Number: 5479 Wooden Hawk Circle
10f. Zip Code: 20144
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Farm

17. Father's Name (First, Middle, Last): William Smith
18. Mother's Name (First, Middle, Maiden Surname): Nora Holland

19a. Informant's Name/Relationship (Type, Print): Dorothy Moore (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8703 Hayshed Ln.,#24, Columbia, MD 21045

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hopkins Church Cem. | Date: 2/20/99
20c. Location - City or Town, State: Highland, MD

21. Signature of Funeral Service Licensee: George R. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — Approximate Interval Between Onset and Death: 6 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bruce Conger Internist
29c. License number: D37013
29d. Date signed (Month, Day, Year): Feb 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bruce M Conger MD #210 11055 Little Patuxent Pkwy, Columbia, MD 21044

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06471

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edna Snyder
2. Date of Death (Month, Day, Year): February 12, 1999
3. Time of Death: 0245A
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-32-9449
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 10, 1935
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3025 Ferndale Street
10f. Zip Code: 20895
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Receiving Department
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Martin Dare
18. Mother's Name (First, Middle, Maiden Surname): Myrtle P. Gover

19a. Informant's Name/Relationship (Type, Print): Bryce M. Snyder, Sr. (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3025 Ferndale Street, Kensington, MD 20895

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: 2/16/99
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Steven D Stroud
22. Name and Address of Facility: Francis J. Collins Funeral Home, inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Breast Cancer — Approximate Interval Between Onset and Death: One Year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD
29c. License number: 033686
29d. Date signed (Month, Day, Year): February 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenneth Mills, MD 18111 Prince Philip Dr. Olney, MD 20832

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06472

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Phyllis C. Spany
2. Dete of Deeth (Month, Day, Yaer): February 13, 1999
3. Time of Death: 11:40PM
4e Facility Name (If not institution, give street end number): Manor Care Fernwood
4b. City, Town, or Location of Deeth: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 122-12-2751
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 79 Yrs. | If Under 1 Yaar: Months, Deys | If Under 24 Hrs.: Hours, Min.
8. Dete of Birth (Month, Dey, Year): Dec. 4, 1919
9. Birthplece (State or Foreign Country): New York

Usuel Residence of Dacedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 8814 Tuckerman Lane
10f. Zip Code: 20854
10g. Citizen of Whet Country?: United States
11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, atc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Clerical Worker
16b. Kind of Business/Industry: Manufacturing
17. Fethar's Neme (First, Middle, Last): Gabriel Formichelli
18. Mother's Neme (First, Middle, Maiden Sumema): Carmella Colandra
19e. Informent's Neme/Reletionship (Type, Print): Carol S. Byrne/Daughter
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 8814 Tuckerman Lane, Potomac, Maryland 20854
20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Nema of cemetery, cremetory or other place): Montgomery Crematorium, Inc. | Dete: February 15, 1999
20c. Location - City or Town, Stete: Bethesda, Maryland
21. Signature of Funeral Service Licensee: ▶ Neil E. Perry
22. Name end Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue M00803 Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Deeth

Immediate Ceuse (Finel disaasa or condition resulting in death): e. Metastatic Brain Tumor — Months

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest:

b. Breast Cancer — Years

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uea contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Tima of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted. 2☐ Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ Albiol MD

29c. License number: D31319

29d. Date signed (Month, Day, Year): February 15, 1999

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): Loreto S. Albiol, M.D. 8218 Wisconsin Avenue, Bethesda, Maryland 20814

State Registrar

31. Dete filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Penna G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item #7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06473

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Darrel Spears
2. Date of Death (Month, Day, Year): February 13 1999
3. Time of Death: 1:52 pm
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery County

Funeral Director

5. Social Security Number: 412-68-4454
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 55 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 14, 1943
9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1218 Myrtle Avenue
10f. Zip Code: 20912
10g. Citizen of What Country? United States of America
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1961-1966
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Checker
16b. Kind of Business/Industry: Retail Food Store (Safeway)
17. Father's Name (First, Middle, Last): James Edward Spears
18. Mother's Name (First, Middle, Maiden Surname): Eula Sappington
19a. Informant's Name/Relationship (Type, Print): Eula F. Spears /Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1303 Daniel Drive, Paragould, Arkansas 72450
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lulu Cemetery; Date: February 16, 1999
20c. Location - City or Town, State: Cardwell, Missouri
21. Signature of Funeral Service Licensee: Howard Causey
22. Name and Address of Facility: Mitchell Funeral Home, P.O. Box 57, Paragould, Arkansas 72450

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Laryngeal Cancer with pulmonary Metastasis 3 yrs
Due to (or as a consequence of):
b. Chronic obstructive lung disease 10 yrs.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Smith S. Ho MD
29c. License number: D21900
29d. Date signed (Month, Day, Year): February 14, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SMITH S. HO 7610 Carroll Ave #280 Takoma Park Md. 20912

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06474

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE STEINBERG
2. Date of Death (Month, Day, Year): February 10, 1999
3. Time of Death: 1:40 PM
4a. Facility Name (If not institution, give street and number): Future Care Cherrywood
4b. City, Town, or Location of Death: Reisterstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 061-05-7178
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): June 9, 1903
9. Birthplace (State or Foreign Country): St. Louis, MO

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 2107 Cedar Circle
10f. Zip Code: 21228
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1940-1942
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Recorded Music- Retail
17. Father's Name (First, Middle, Last): Jacob Steinberg
18. Mother's Name (First, Middle, Maiden Surname): Anna Chika
19a. Informant's Name/Relationship (Type, Print): Ronald Steinberg, Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2107 Cedar Circle Drive, Catonsville, Maryland 21228
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Lebanon Cemetery | Date: Feb. 12,1999
20c. Location - City or Town, State: Glendale, New York
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Takoma Funeral Home, Inc. 254 Carroll Street, NW, Washington, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Carcinoma of liver — Approximate Interval Between Onset and Death: 90 days

Due to (or as a consequence of): b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: 03288
29d. Date signed (Month, Day, Year): 2/11/99 Feb.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Moss, M.D., 114 Business Center Drive, Reisterstown, Maryland 21136

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06475

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia D. Stewart
2. Date of Death (Month, Day, Year): February 12, 1999
3. Time of Death: 4:45 AM
4a. Facility Name (If not institution, give street and number): 405 Edmonston Drive
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 470-22-7391
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 8, 1926
9. Birthplace (State or Foreign Country): Minnesota

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 405 Edmonston Drive
10f. Zip Code: 20851
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Special Education Instructional Assistant
16b. Kind of Business/Industry: Montgomery County Public Schools

17. Father's Name (First, Middle, Last): Edward Fallon
18. Mother's Name (First, Middle, Maiden Surname): Mary Connors

19a. Informant's Name/Relationship (Type, Print): James W. Stewart, Jr./Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 405 Edmonston Drive, Rockville, Maryland 20851

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. — Date: Feb. 13, 1999
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — Approximate Interval Between Onset and Death: 18 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D44157
29d. Date signed (Month, Day, Year): February 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ira Berger, M.D. 809 Veirs Mill Road, Rockville, Maryland 20851

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06476

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Mollie Bell Stover
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 9:15 a.m.
4a. Facility Name (If not institution, give street end number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 220-16-0257
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 1, 1921
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10e. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Boyds
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 14800 Schaeffer Road
10f. Zip Code: 20841
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4or 5+):
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Line Leader
16b. Kind of Business/Industry: Watkins and Johnson

17. Father's Name (First, Middle, Last): James E. Reese
18. Mother's Name (First, Middle, Maiden Sumame): Addie May Joseph

19e. Informent's Name/Relationship (Type, Print): Yvonne K. Schwartzbeck (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14800 Schaeffer Road, Boyds, MD 20841

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 2-12-99
20c. Location - City or Town, Stete: Beltsville, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature] M00956
22. Name end Address of Fecility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA — 7 DAYS
Due to (or es e consequence of):
b. Pulmonary Fibrosis — 20 YEARS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Pert II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given In Pert I.
OSTEOARTHRITIS
DIABETES Mellitus

23b. Did tobacco usa contribute to the causa of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)
27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the ceuse(s) and manner stated.
29b. Signature end title of certifier: ▶ [signature]
29c. License number: D33719
29d. Date signed (Month, Day, Year): February 11, 1999
30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): Paul T. Wielebinski, M.D.
19261 Montgomery Village Ave G-14 Gaithersburg, MD 20877

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06477

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry Egbert Stowers, Jr.
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 6:00 AM
4a. Facility Name (If not institution, give street and number): Andrus House
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-24-4106
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept.23,1921
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: none
10b. County: none
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4000 Tunlaw Road,N.W. #927
10f. Zip Code: 20007
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: 42-45 50-52
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): executive
16b. Kind of Business/Industry: telephone company
17. Father's Name (First, Middle, Last): Henry Egbert Stowers, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Naomi Cloud
19a. Informant's Name/Relationship (Type, Print): Robert A. Stowers/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4000 Tunlaw Rd.,N.W.,#927, Washington, D.C. 20007
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory — Date: 2-16-99
20c. Location - City or Town, State: Alexandria, Va.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DeVol Funeral Home, 2222 Wisconsin Ave.,N.W.,Washington,DC 20007

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Aspiration Pneumonia, recurrent — 3 Months
Due to (or as a consequence of):
b. Dysphagia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Alzheimer's Disease — 5 Years
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Seizure Disorder, Urinary Retention

Decubitus Ulcers, Gastrostomy Tube

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D35579
29d. Date signed (Month, Day, Year): February 12, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Susan J. Miller, M.D., 6844 Tulip Hill Terrace, Bethesda, Md. 20816

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Denise B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06478

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERTRAM W. STRAUSS
2. Date of Death: Month 2 Day 18 Year 99
3. Time of Death: 8:25AM
4a. Facility Name (If not institution, give street and number): Collington Episcopal Life Care
4b. City, Town, or Location of Death: Mitchelville
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 578-34-5882
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 97 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10 10 01
9. Birthplace (State or Foreign Country): IOWA

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Mitchelville
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No
10e. Street and Number: 16450 LOTTSFORD
10f. Zip Code: 20721
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 4 YEARS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMINISTRATOR
16b. Kind of Business/Industry: GOVERNMENT

17. Father's Name (First, Middle, Last): LEON STRAUSS
18. Mother's Name (First, Middle, Maiden Surname): BERTHA SHEUERMAN

19a. Informant's Name/Relationship (Type, Print): HELEN SEITZ (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 771-D SOUTH 2ND STREET, PHILADELPHIA, PA. 19147

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GEORGETOWN MED. SCH. — Date: 2/18/99
20c. Location - City or Town, State: WASHINGTON, D.C.

21. Signature of General Service Licensee: [signature]
22. Name and Address of Facility: AUSTIN ROYSTER FUNERAL HOME, 3821 14TH ST. N.W., WASH, DC. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Advanced Dementia.	5 yrs.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Type II, Depression, Diabetic Gastroparesis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature]
29c. License number: D31001
29d. Date signed (Month, Day, Year): 2/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart J. Turkewitz, M.D. 7500 Greenway Cntr. Dr. #430 Greenbelt, MD. 20770

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: [signature] B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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2

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 06479

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ADELAIDE SOMERS
2. Date of Death (Month, Day, Year): FEBRUARY 11, 1999
3. Time of Death: 3:50AM
4a. Facility Name (If not institution, give street and number): MARINER HEALTH CENTER
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-07-9073
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): FEB. 24 1905
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1001 SPRING STREET #915
10f. Zip Code: 20902
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: CAUCASIAN
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EXECUTIVE SECRETARY
16b. Kind of Business/Industry: U.S. LABOR DEPARTMENT
17. Father's Name (First, Middle, Last): JOHN WOODFORD
18. Mother's Name (First, Middle, Maiden Surname): KATIE LOWE
19a. Informant's Name/Relationship (Type, Print): AUGUSTINE GONZALO FRIEND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5500 FRIENDSHIP BLVD. #1218 CHEVY CHASE MD 20815
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MOUNT COMFORT CREMATORY
Date: 2-13-99
20c. Location - City or Town, State: ALEXANDRIA, VA
21. Signature of Funeral Service Licensee: Melvin C. Powell
22. Name and Address of Facility: AFFORDABLE FUNERAL SERVICES 2230 GALLOWS ROAD #110 DUNN LORING, VA 22027

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. ACUTE MYOCARDIAL INFARCTION — Approximate Interval Between Onset and Death: IMMEDIATE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DYSPHAGIA

FEBRILE ILLNESS

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P. Henjum MD
29c. License number: D35045
29d. Date signed (Month, Day, Year): FEBRUARY 11,1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PHILIP HENJUM,MD 3416 OLANDWOOD COURT #204 OLNEY MARYLAND 20832

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06480

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BARTHOLOMEW SALVADORE SPANO
2. Date of Death: Month FEB. Day 15, Year 1999
3. Time of Death: 3:35 AM
4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 123-07-1652
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 8, 1918
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: CHEVY CHASE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3204 CUMMINGS LA.
10f. Zip Code: 20815
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1939-1954
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ENGINEER
16b. Kind of Business/Industry: AERONAUTICS
17. Father's Name (First, Middle, Last): BARTHOLOMEW SPANO
18. Mother's Name (First, Middle, Maiden Surname): CONCETTA YACANO
19a. Informant's Name/Relationship (Type, Print): PARI SPANO/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHAMBERS CREMATORY
Date: 2/16/99
20c. Location - City or Town, State: RIVERDALE, MD.
21. Signature of Funeral Service Licensee: W. W. Chambers M00091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Spano, Bartholomew S., 2/15/99 0335 (5)

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure — 21 days
Due to (or as a consequence of):
b. Pneumonia — 21 days
Due to (or as a consequence of):
c. Congestive heart failure — 4 days
Due to (or as a consequence of):
d. Acute cholecystitis c̄ S. faecalis Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William E. Battle
29c. License number: MD 40203
29d. Date signed (Month, Day, Year): Feb 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM E. BATTLE, M.D., 5530 WISCONSIN AVE. #750, CHEVY CHASE, MD. 20815

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06481

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elsie F. Sampson
2. Date of Death: Month 02 Day 13 Year 99
3. Time of Death: 3:15 P.M.
4a. Facility Name (If not institution, give street and number): Caroline Nursing Home, Inc.
4b. City, Town, or Location of Death: Denton, Maryland
4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 212-16-1159
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 26, 17
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: Md.
10b. County: Caroline
10c. City, Town or Location: Denton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 802 Riverview Gardens
10f. Zip Code: 21629
10g. Citizen of What Country? U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 05 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Factory
17. Father's Name (First, Middle, Last): George Flamer
18. Mother's Name (First, Middle, Maiden Surname): Cora Nichols
19a. Informant's Name/Relationship (Type, Print): William Smith/ Caregiver
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11683 Eveland rd. Ridgley, Md. 21641
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sandtown cemetery — Date: 2/20/99
20c. Location - City or Town, State: Hillsborough, Md.
21. Signature of Funeral Service Licensee: ▶ Eric Dashiell
22. Name and Address of Facility: 302 East Ave Easton Md. 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure — Approximate Interval Between Onset and Death: 2 d
Due to (or as a consequence of):
b. NI DM — 20 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D00 51132
29d. Date signed (Month, Day, Year): 2-16-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Jorge Abrego 609 Daffin Lane, Denton, MD 21629

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06482

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Henry Scott
2. Date of Death (Month, Day, Year): Feb. 15, 1999
3. Time of Death: 1447
4a. Facility Name (If not institution, give street and number): Kent & Queen Anne's Hospital
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 214-28-8668
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 31, 1929
9. Birthplace (State or Foreign Country): Ruthsburg, MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Anne's
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 212 Central Drive
10f. Zip Code: 21620
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Store Clerk
16b. Kind of Business/Industry: Acme Markets
17. Father's Name (First, Middle, Last): Herman Scott
18. Mother's Name (First, Middle, Maiden Surname): Emma Mae Clark
19a. Informant's Name/Relationship (Type, Print): Anna Virginia Scott/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 212 Central Drive, Chestertown, MD 21620
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crumpton Cemetery
Date: 2/18/99
20c. Location - City or Town, State: Crumpton, MD
21. Signature of Funeral Service Licensee: ▶ Kirk A. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardiac Arrest — 1 Hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Asthmatic Bronchitis
H/O Heart Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D0005754
29d. Date signed (Month, Day, Year): 2-17-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Ralph E. Libby, 204 Medical Center Road, Grasonville, MD 21638

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06483

Shelton, Marshall Edward

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARSHALL EDWARD SHELTON
2. Date of Death (Month, Day, Year): FEB. 17 1999
3. Time of Death: 2005
4a. Facility Name (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 215-32-3660
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): MAR 13, 1910
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 658 LUCABAUGH MILL ROAD
10f. Zip Code: 21157
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FARMER
16b. Kind of Business/Industry: AGRICULTURE

17. Father's Name (First, Middle, Last): JOHN EZRA SHELTON
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): MARY AGNES SHELTON/EX-WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 571/2 Hoff Road, Union Bridge 21791

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gard. | Date: 2/22
20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Jennifer L. Scherr
22. Name and Address of Facility: 91 WILLIS STREET MYERS FUNERAL HOME WESTMINSTER, MD 21157

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Recurrent Arrhythmia Pneumonia — Approximate Interval Between Onset and Death: 1 week
Due to (or as a consequence of):
b. Acute vascular Accident — 7 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure Arteriosclerotic Cardiovascular Disease Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Datta M.D.
29c. License number: D 58079
29d. Date signed (Month, Day, Year): February 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Datta 334 Mill St. Hagerstown Md. 21740

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06484

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vincent B. Terlep, Jr.
2. Date of Death (Month, Day, Year): February 14, 1999
3. Time of Death: 10:10 AM
4e. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 303-48-5206
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 5, 1946
9. Birthplace (State or Foreign Country): Indiana

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4426 Ambler Drive
10f. Zip Code: 20895
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attorney
16b. Kind of Business/Industry: Law

17. Father's Name (First, Middle, Last): Vincent B. Terlep, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Lucy Ward

19a. Informant's Name/Relationship (Type, Print): Kathleen M. Terlep (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4426 Ambler Drive, Kensington, MD 20895

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: 2/18/99
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: ▶ Matthew [illegible]
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarction	immediate
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Coronary Atherosclerosis	12 years
Due to (or as a consequence of):		
	c. Hyperlipidemia	15 years
Due to (or as a consequence of):		
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Richard E. Rubin MD
29c. License number: D 21154 - MD
29d. Date signed (Month, Day, Year): February 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard E. Rubin, M.D 5530 Wisconsin Avenue, Chevy Chase, MD 20815

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

18

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06485

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth H. Thiebeau
2. Date of Death (Month Day Year): February 13, 1998
3. Time of Death: 2:27pm.
4a. Facility Name (If not institution, give street and number): Doctors Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's Co.

Funeral Director

5. Social Security Number: 074-09-2662
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): April 7, 1915
9. Birthplace (State or Foreign Country): New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6727 Lamont Drive
10f. Zip Code: 20706
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: University of Maryland

17. Father's Name (First, Middle, Last): Earl Harris
18. Mother's Name (First, Middle, Maiden Surname): Helena Lasher

19a. Informant's Name/Relationship (Type, Print): Barbara T. Fustich (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory | Date: 2/14/1999
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service License: Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC BREAST CANCER
Due to (or as a consequence of):
b. SEPSIS
Due to (or as a consequence of):
c. ACUTE RESPIRATORY DISTRESS SYNDROME
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D50686
29d. Date signed (Month, Day, Year): 2/14/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): GURDEEP SINGH CHHABRA 50 West Edmonston Road, #303 Rockville, Maryland 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Ruth Harris Thiebeau

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06486

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond Webb Thompson, Jr.
2. Date of Death (Month, Day, Year): February 14, 1999
3. Time of Death: 2:13 a.m.
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 212-38-8059
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 12, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 9707 Old Georgetown Road
10f. Zip Code: 20815
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Officer
16b. Kind of Business/Industry: U.S. Navy
17. Father's Name (First, Middle, Last): Raymond Webb Thompson
18. Mother's Name (First, Middle, Maiden Surname): Ethel Classen
19a. Informant's Name/Relationship (Type, Print): Robert Thompson Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9716 W. Bexhill Drive, Kensington, MD 20895
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Hill Cemetery
Date: 2/18/99
20c. Location - City or Town, State: Washington, D.C.
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W., Washington, D.C. 20016

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — Approximate Interval Between Onset and Death: 1 week
Due to (or as a consequence of):
b. Cancer - unknown primary — 2 months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D29229
29d. Date signed (Month, Day, Year): 2/14/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martin S Kanasky MD 5530 Wisconsin Ave #730 Chevy Chase MD 20815

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Raymond Thompson 2-14-99 2:13 AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06487

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Howard Willis Thorn
2. Date of Death (Month, Day, Year): February 14 1999
3. Time of Death: 3:50 A.M.
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-44-7671
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 3 1912
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 10413 Mercado Way
10f. Zip Code: 20886
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Engineer
16b. Kind of Business/Industry: Engineering
17. Father's Name (First, Middle, Last): Willis Henry Thorn
18. Mother's Name (First, Middle, Maiden Surname): Henrietta Wellbrock
19a. Informant's Name/Relationship (Type, Print): Dorothy Northrop Thorn / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10413 Mercado Way Gaithersburg, Maryland 20886
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 2/15/99
20c. Location - City or Town, State: Alexandria, Virginia
21. Signature of Funeral Service Licensee: ▶ Gary C. Wan
22. Name and Address of Facility: DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, Md. 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Cardiomyopathy	years
	Due to (or as a consequence of):	
	c. Hypertension	years
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ S. Abulfarag
29c. License number: 31391 D
29d. Date signed (Month, Day, Year): February 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUHAIR ABULFARAG 481 N. FREDERICK AVE. #230 GAITHERSBURG, MD. 20879

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

24

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06488

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jean Trevas
2. Date of Death (Month Day Year): Feb. 13, 1999
3. Time of Death: 3:50am
4a. Facility Name (If not institution, give street and number): 204 E. Indian Spring Drive
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 086-12-1432
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Dec 21, 1913
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 204 E. Indian Spring Drive
10f. Zip Code: 20901
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Credit Union
16b. Kind of Business/Industry: AFLCIO

17. Father's Name (First, Middle, Last): Alexander Goldstein
18. Mother's Name (First, Middle, Maiden Surname): Evelyn Kramer

19a. Informant's Name/Relationship (Type, Print): Suzanne Rosenblatt (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11501 Gauguin La Potomac, MD 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King David Mem. Gardens
Date: 2/15/99
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc 1170 Rockville Pike Rockville, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — DAYS
Due to (or as a consequence of):
b. DIABETES MELLITUS — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE, DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D36046
29d. Date signed (Month, Day, Year): 2/14/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN J. MERENDINO JR, MD 4701 RANDOLPH RD #216 ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #20b,20c,2/22/99,BMW,Montg.Co

Certificate of Death

Reg. No. 99 06689

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rim Trifi
2. Date of Death: Month February Day 18 Year 1999
3. Time of Death: 5:50 AM
4a. Facility Name (If not institution, give street and number): Mariner Post Acute Network-Circle Manor
4b. City, Town, or Location of Death: Kensington, MD
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-45-0639
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 20 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 10, 1978
9. Birthplace (State or Foreign Country): Tunisia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 16508 Redland Road
10f. Zip Code: 20855
10g. Citizen of What Country?: Tunisia

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Tunisian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Salem Trifi
18. Mother's Name (First, Middle, Maiden Surname): Najoua Benabid

19a. Informant's Name/Relationship (Type, Print): Najoua Benabid, Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16508 Redland Road, Rockville, MD 20855

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Zalaz Cemetery ~~Unknown~~ Date: 2/24/99 ~~Unknown~~
20c. Location - City or Town, State: Tunis, Tunisia ~~Unknown~~

21. Signature of Funeral Service Licensee: Gary M. [illegible]
22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. Acute intermittent Porphyria — Approximate Interval Between Onset and Death: years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeanne P. Asher MD
29c. License number: D34092
29d. Date signed (Month, Day, Year): 2/18/99

30. Name and address of person who completed cause of death (item 23a) (Type, Print): JEANNE P. ASHER MD 3720 FARRAGUT AVE KENSINGTON MD 20895

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: Denise G. Sparks

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06490

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hattie W. Toltesy
2. Date of Death (Month, Day, Year): February 17, 1999
3. Time of Death: 8:25 P.M.
4a. Facility Name (If not institution, give street and number): Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 148-24-3152
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 19, 1911
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5221 Marlyn Drive
10f. Zip Code: 20816
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): John Wiley Wood
18. Mother's Name (First, Middle, Maiden Surname): Hassie Robinson

19a. Informant's Name/Relationship (Type, Print): Paula Toltesy Valad/ Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5221 Marlyn Drive Bethesda, Maryland 20816

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium Inc. | Date: February 19, 1999
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature] M00335
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Arterial Occlusion — Approximate Interval Between Onset and Death: 48 hours

Due to (or as a consequence of): b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Elliot R. Goldstein
29c. License number: D03581
29d. Date signed (Month, Day, Year): February 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elliot Goldstein 9410 Old Georgetown Rd. Bethesda, Md 20814

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06491

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald D. Twiford
2. Date of Death (Month Day Year): February 14, 1999
3. Time of Death: 10:05 AM
4a. Facility Name (If not institution, give street and number): 706 Hyde Road
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 568-24-5030
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 17, 1911
9. Birthplace (State or Foreign Country): Nebraska

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 706 Hyde Road
10f. Zip Code: 20902
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Educational Psychologist
16b. Kind of Business/Industry: Psychology

17. Father's Name (First, Middle, Last): John Twiford
18. Mother's Name (First, Middle, Maiden Surname): Jennie Barton

19a. Informant's Name/Relationship (Type, Print): Guinevere Twiford (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 706 Hyde Road, Silver Spring, MD 20902

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park
Date: 2/20/99
20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: Steven D Strand
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrest

Due to (or as a consequence of):
b. Arteriosclerosis

Due to (or as a consequence of):
c. Atherosclerosis

Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward J Richards MD
29c. License number: D12703
29d. Date signed (Month, Day, Year): February 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward J. Richards, M.D. 10301 Georgia Avenue, Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year): FEB 17 1999
32. Registrar's Signature: Jenine G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1071

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06492

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLARENCE STANLEY TURNER SR
2. Date of Death: Month 02 Day 13 Year 99
3. Time of Death: 450 AM
4a. Facility Name (If not institution, give street and number): KENT & QUEEN ANNE'S HOSPITAL
4b. City, Town, or Location of Death: CHESTERTOWN
4c. County of Death: KENT

Funeral Director

5. Social Security Number: 217-12-4648
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 77 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02-09-1922
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: KENT
10c. City, Town or Location: CHESTERTOWN
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 343 CANNON ST
10f. Zip Code: 21620
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FACTORY WORKER
16b. Kind of Business/Industry: CAMPBELL SOUP

17. Father's Name (First, Middle, Last): CHARLES HENRY TURNER
18. Mother's Name (First, Middle, Maiden Surname): GERTRUDE BROWN

19a. Informant's Name/Relationship (Type, Print): ANTIONETTE D. BUTCHER - GRANDDAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 107 ROOSEVELT DRIVE. CHESTERTOWN, MD 21620

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): JANES CEMETERY
Date: 2-20-99
20c. Location - City or Town, State: CHESTERTOWN, MD

21. Signature of Funeral Service Licensee: Joyce O. Walley
22. Name and Address of Facility: WALLEY FUNERAL HOME - CHESTERTOWN, MD 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Adenocarcinoma. Metastatic Colon Cancer. Mets to Lung & Liver. — Approximate Interval Between Onset and Death: 11 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HTN, Anemia.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D50996
29d. Date signed (Month, Day, Year): 2/16/99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NEIL STODDARD, M.D. · MEDICAL BLDG · BROWN ST. CHESTERTOWN, MD 21620

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: N. Sparks

To be Completed by Funeral Director

To be Completed by Physician/Medical Examiner

Medical Certification: To be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

99-0838-019
B.K.S
JAMES THOMAS
ITEMS. #23 PART I, 27 PER MEO G769 3-3-99 WR.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06493

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES TOWNSEND THOMAS
2. Date of Death (Month, Day, Year): FEB. 13, 1999
3. Time of Death: 0938 AM
4a. Facility Name (If not institution, give street and number): 5251 GYPSY DRIVE
4b. City, Town, or Location of Death: CAMBRIDGE
4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 217-30-9121
6. Sex: ☒ 1 M 2 F
7. Age (In yrs. last birthday): 62 Yrs. — If Under 1 Year: Months, Days — If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): May 29 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: ☒ 1 Yes 2 No
10e. Street and Number: 5251 Gypsy Drive
10f. Zip Code: 21613
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 Never Married 2 Married 3 Widowed ☒ 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☒ 1 Yes 2 No — If Yes, Give Year or Dates: 1953-62
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes ☒ 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): mariner-3rd Officer
16b. Kind of Business/Industry: merchant marine
17. Father's Name (First, Middle, Last): James Townsend Thomas
18. Mother's Name (First, Middle, Maiden Surname): Pauline Townsend
19a. Informant's Name/Relationship (Type, Print): Jacqueline A. Potts-daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5251 Gypsy Drive, Cambridge MD 21613
20a. Method of Disposition: ☒ 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cemetery — Date: 2-17
20c. Location - City or Town, State: Hurlock, Maryland
21. Signature of Funeral Service Licensee: Kenneth R. Thomas Jr.
22. Name and Address of Facility: Thomas Funeral Home PA, 700 Locust St. Cambridge MD 21613

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ATHESOCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 Yes 2 No 3 Probably ☒ 4 Unknown

24a. Was an autopsy performed? ☒ 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? ☒ 1 Yes 2 No

25. Was case referred to medical examiner? ☒ 1 Yes 2 No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA — Other: 4 Nursing Home ☒ 5 Residence 6 Other (Specify)

27. Manner of Death: ☒ 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): FEB. 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06494

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grace O. Valencia
2. Date of Death (Month, Day, Year): February 11, 1999
3. Time of Death: 12:35 PM
4a. Facility Name (If not institution, give street and number): Springbrook Adventist Nursing & Rehabilitation
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-03-0073
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 29, 1917
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8508 Barron Street
10f. Zip Code: 20912
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Rutilio Oreto
18. Mother's Name (First, Middle, Maiden Surname): Maria Sciuto

19a. Informant's Name/Relationship (Type, Print): Hansel A. Valencia (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8508 Barron Street, Takoma Park, MD 20912

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: 2/15/99
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Bilateral Intracerebral Hemorrhage	< 6 mos.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Deep Venous Thrombosis, Hypertension, Hyperlipidemia, Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature]
29c. License number: D31001
29d. Date signed (Month, Day, Year): 2/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart J. Turkewitz, M.D. 7500 Greenway Ctr. Dr. #430 Greenbelt, MD. 20770

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 396-3693, Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06495

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Lillian VanderSys
2. Date of Death (Month, Day, Year): February 12, 1999
3. Time of Death: 3:20 P.M.
4a. Facility Name (If not institution, give street and number): College View Center
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 212-76-6765
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 7 1913
9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 20111 Woodfield Road
10f. Zip Code: 20882
10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Samuel McWilliams
18. Mother's Name (First, Middle, Maiden Surname): Beatrice Poole

19a. Informant's Name/Relationship (Type, Print): John L. Vander Sys / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20111 Woodfield Road, Gaithersburg, Md. 20882

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 2/14/99
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Muriel H. Barber
22. Name and Address of Facility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Maryland 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASPIRATION PNEUMONIA	6 HOURS
Due to (or as a consequence of):	b. BOWEL OBSTRUCTION	5 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA, RESPIRATORY INSUFFICIENCY, CARDIAC DISEASE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Yong Lee, MD
29c. License number: D0050767
29d. Date signed (Month, Day, Year): 02/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Yong Lee, M.D., 174 Thomas Johnson Drive, Frederick, Maryland 21702

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06496

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank Michael Wells
2. Date of Death (Month, Day, Year): February 13, 1999
3. Time of Death: 5:05 AM
4a. Facility Name (If not institution, give street and number): 8904 Falls Chapel Way
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 085-24-3960
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): April 20, 1932
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8904 Falls Chapel Way
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Korea
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Vice President
16b. Kind of Business/Industry: Management Consulting

17. Father's Name (First, Middle, Last): Frank Walton
18. Mother's Name (First, Middle, Maiden Surname): Louise Lynch

19a. Informant's Name/Relationship (Type, Print): Nancy Lou Wells/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8904 Falls Chapel Way, Potomac, Maryland 20854

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Mausoleum | Date: Feb. 17, 1999
20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: [signature] M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Brain Tumor	2 years
Due to (or as a consequence of): b.	Seizure	6 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D40353
29d. Date signed (Month, Day, Year): February 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Yan, M.D. 11119 Rockville Pike, Rockville, Maryland 20852

To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06497

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MURIEL S. WEST
2. Date of Death (Month, Day, Year): February 10, 1999
3. Time of Death: 8:35 PM
4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-46-1505
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 2, 1909
9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State:
10b. County:
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1509 Van Buren Street, N.W.
10f. Zip Code: 20012
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Non-Profit Organization
17. Father's Name (First, Middle, Last): Clarence Wilson
18. Mother's Name (First, Middle, Maiden Surname): Mamie Bellmon
19a. Informant's Name/Relationship (Type, Print): John West/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1509 Van Buren St., Washington, D.C. 20012
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc. — Date: 2/13/99
20c. Location - City or Town, State: Beltsville, MD
21. Signature of Funeral Service Licensee: Marvin E. Heath
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

Physician Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	ONE WEEK
	Due to (or as a consequence of):	
	b. ALZHEIMER'S DEMENTIA	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Martin C. Shargel M.D.
29c. License number: D08944
29d. Date signed (Month, Day, Year): February 11, 1999

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Martin C. Shargel, M.D. 3720 Farragut Avenue, Kensington, Maryland 20895-2110

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: Geneva G. Sparks

To Be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 06498

AMEND ITEM#10a-f PER F.H. G773 7-23-99 J.A.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret I. Willever
2. Date of Death (Month, Day, Year): FEBRUARY 16, 1999
3. Time of Death: 8:20 PM
4a. Facility Name (If not institution, give street and number): WILSON HEALTH CARE CENTER
4b. City, Town, or Location of Death: GAITHERSBURG
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 150-30-5120
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 11, 1902
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: ~~Maryland~~ JERSEY
10b. County: ~~Montgomery~~ WARREN
10c. City, Town or Location: ~~Gaithersburg~~ PJILLIPSBURG
10d. Inside City Limits: ~~1☒ Yes~~ 2☒ No
10e. Street and Number: ~~301 Russell Avenue~~ 517 GUY ROAD
10f. Zip Code: ~~20877~~ 08865
10g. Citizen of What Country? United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): August Irmer
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN Rimler

19a. Informant's Name/Relationship (Type, Print): Clayton Willever/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 517 Guy Road, Phillipsburg, New Jersey 08865

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Saint James Lutheran Church Cemetery
Date: February 26, 1999
20c. Location - City or Town, State: Greenwich Township New Jersey

21. Signature of Funeral Service Licensee: ▶ Howard A Cowan
22. Name and Address of Facility: Rupell Funeral Home, 465 Memorial Park, Phillipsburg, NJ 08865

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. aspiration pneumonitis	hours
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. dementia	years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Parkinson's disease, osteoarthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ P Callahan Lyon MD
29c. License number: D41794
29d. Date signed (Month, Day, Year): February 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. Callahan-Lyon, MD 911 Russell Ave Gaithersburg, MD 20879

State Registrar

31. Date filed (Month, Day, Year): FEB 19 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06499

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Theresa Wilson
2. Date of Death (Month Day Year): February 12, 1999
3. Time of Death: 10:00 AM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 083-48-4313
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): March 20, 1934
9. Birthplace (State or Foreign Country): West Trinidad, Indies

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1704 Alberti Drive
10f. Zip Code: 20902
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Angelo Wilson
18. Mother's Name (First, Middle, Maiden Surname): Inez Apping

19a. Informant's Name/Relationship (Type, Print): Bobby Aming (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1704 Alberti Drive, Silver Spring, MD 20902

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: 2/19/99
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: ▶ J. Kevin Gutowski
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Valvular Heart disease	Many years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Congestive Heart failure	Many years
	Due to (or as a consequence of): c. Stroke	2 Months
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Cohen Shomler
29c. License number: D43496
29d. Date signed (Month, Day, Year): 2-14-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MOHAMMAD A KHALID MD 8630- Fenton Street Silverspring MD 20910

State Registrar

31. Date filed (Month, Day, Year): FEB 18 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 06500

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hugh Chester Wintermoyer
2. Date of Death (Month Day Year): February 12, 1999
3. Time of Death: 12:06 AM
4a. Facility Name (If not institution, give street and number): 808 Loxford Terrace
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 235-18-7835
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 17, 1921
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 808 Loxford Terrace
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 1940-60
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Officer / FAA Controller
16b. Kind of Business/Industry: US Air Force / Aviation

17. Father's Name (First, Middle, Last): Charles Wesley Wintermoyer
18. Mother's Name (First, Middle, Maiden Surname): Pearl Blanche Fuss

19a. Informant's Name/Relationship (Type, Print): Janice M. Wintermoyer (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 808 Loxford Terrace, Silver Spring, MD 20901

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cemetery — Date: 2/22/99
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Steven D Strand
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Widespread Metastases — months
Due to (or as a consequence of):
b. Carcinoma of the Lung
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D02338
29d. Date signed (Month, Day, Year): February 12, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard P. Delaney 9801 Georgia Avenue, Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year): FEB 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

(B) permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10+1